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Ontario
Automobile
Insurance
Board

Reference

An examination of threshold no fault and choice no fault systems of privately delivered automobile insurance.

REPORT

TO

THE LIEUTENANT GOVERNOR IN COUNCIL

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Ontario

Ontario
Automobile
Insurance
Board

Commission de
l'assurance-
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July 18, 1989

The Honourable Murray J. Elston
Minister of Financial Institutions
7th Floor
Frost Building South
7 Queen's Park Crescent
Toronto, Ontario
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Dear Mr. Minister:

In accordance with an Order in Council dated March 2, 1989, the Ontario Automobile Insurance Board conducted a hearing to examine a threshold no fault system of privately delivered automobile insurance (with two, alternative, verbal thresholds) and a choice system of privately delivered automobile insurance (with alternative tort and no fault options).

The Report of the Board is hereby respectfully submitted.

Sincerely,

John P. Kruger

104-07306/

R-89-1

IN THE MATTER OF the Ontario Automobile Insurance Board Act, 1988, S.O. 1988, c.18;

AND IN THE MATTER OF a reference made by the Lieutenant Governor in Council pursuant to section 28 of the said Act.

BEFORE

John P. Kruger
Chairman and Presiding Member

M. Elizabeth Atcheson
Vice Chair

M. Patricia Richardson
Vice Chair

July 14, 1989

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EXECUTIVE SUMMARY

This Report arises from an Order in Council dated March 2, 1989 from the Lieutenant Governor in Council. The Reference required that the Board examine a threshold no fault system of privately delivered automobile insurance (with two, alternative, verbal thresholds) and a choice system of privately delivered automobile insurance (with alternative tort and no fault options).

A complete introduction to the Report will be found in Chapter 1.

The Report speaks for itself with respect to its analysis of the evidence and findings of the Board. The Board has given the evidence its most careful consideration and the findings are put forward in as measured and balanced a way as possible.

The findings are listed below.

FINDINGS

Chapter 3 - Level of Recovery

1. There exists among Ontario consumers the perception that insurance premiums are too high (paragraph 3.10).

2. There is a need to increase existing no fault benefits contained in Section B of the automobile insurance policy, SPF 1. The proposed enhanced no fault benefits -- particularly the disability income benefits and rehabilitation, medical and long term care benefits -- represent a substantial improvement over current no fault benefit levels (paragraphs 3.17 - 3.21).

3. The enriched no fault benefits and any premium savings that would attend implementation of the three no fault systems referred to the Board are accomplished, in large measure, by a reduction in the benefit levels available under the current compensation system, which combines recovery in tort with "add on" no fault benefits under the insurance policy (paragraph 3.22).

The Threshold Options

4. The threshold options referred to the Board preclude recovery in tort for non-economic losses (pain and suffering and loss of amenities of life).

   (a) While Threshold Option 2 (the New York threshold) is less restrictive than Threshold Option 1 (the Michigan threshold), both are capable of denying recovery in respect of serious injuries, involving hospitalization, operations, several months absence from work, chronic pain and long term disability (paragraphs 3.32 - 3.33).

(b) Non-pecuniary losses represent "real" losses. No evidence was presented to the Board that would establish that such losses are unworthy of compensation (paragraph 3.51).

(c) Threshold systems affect in a disproportionate manner moderately injured persons with soft tissue injuries, minor to moderate head injuries, emotional trauma, and other injuries that are not permanent or objectively verifiable. Thresholds that specifically require that injuries be objectively manifested or permanent require very serious analysis, as their only merit appears to be that they save costs (paragraphs 3.34 - 3.36).

(d) Threshold systems may be challenged as operating in a discriminatory manner towards persons who do not earn income, such as homemakers, the young, the aged, and the unemployed, for whom compensation for pain and suffering represents the major, or sole, portion of a personal injury award (paragraph 3.49).

(e) The elimination of a right of action for non-economic loss below the threshold will discourage the assertion of claims for economic loss, as the latter will in many cases not be economically viable if asserted alone (paragraph 3.37).

Choice No Fault

5. The choice no fault option referred to the Board eliminates entirely the right to sue for both economic and non-economic loss.

(a) Compared to levels of recovery available to those who are not at fault under the current system and under the referred threshold systems, choice no fault would represent much lower levels of recovery (paragraph 3.39).

(b) While denial of non-economic loss would be extended under this option to all injured persons, the impact of the denial of economic loss is relatively more severe (paragraphs 3.40 - 3.41).

(c) The most severely affected include the catastrophically injured, dependants of a deceased, those with above average incomes, young persons, persons with above average earning capacity, and others whose income level at the time of injury does not reflect their earning capacity (paragraph 3.42).

Analysis of Compensation Levels

6. The superior levels of compensation that may be awarded under the tort system are available only where the injury is caused by the fault of another and where policy limits of the tortfeasor or insured are sufficient to cover the losses. No fault systems provide an assured level of benefits to all persons regardless of fault and policy limits (paragraph 3.43).

7. The traditional U.S. rationale for no fault systems, which deny compensation to persons who are not at fault in order to compensate all persons regardless of fault, does not apply equally in Ontario, where injured persons currently have access to no fault benefits under Section

B of the automobile insurance policy, to comprehensive medical coverage under OHIP, and to other universal social welfare programs (paragraphs 3.14 - 3.16, 3.65).

8. The claims of many U.S. proponents of no fault with respect to the superior efficiency of such systems as mechanisms for compensating injured persons are inflated. While no fault systems may involve efficiencies, the Board makes no finding on the matter on the basis of the evidence presented at the Hearing (paragraph 3.67).

9. While the implementation of the enhanced no fault benefits is desirable, this could be accomplished within the framework of the existing system. On the other hand, without adjustment to the current system, the additional benefits could not be provided without premium increases. The primary rationale for the implementation of the enhanced benefits within the context of the referred systems is cost reduction. Whether the enhanced no fault benefits should be financed by means of a reduction in the level of recovery of injured persons who are not at fault is a matter of public policy to be decided by Government (paragraph 3.74, item 9).

10. Premium reduction as a rationale for no fault systems is controversial and may create among consumers unrealistic

expectations concerning the future price of insurance (paragraphs 3.70 - 3.73).

Adequacy Considerations

11. The adequacy of the enriched no fault benefits must be considered in the context of the reparations system within which they are to be delivered. A benefits package that constitutes the sole recourse of an injured victim must be viewed differently from one that eliminates only certain legal rights, or one that is available in conjunction with the right to recover excess economic loss and compensation for non-economic loss. The no fault benefits recommended by Mr. Justice Osborne and included within the referred systems were never intended to operate as part of a threshold or a pure no fault system (paragraphs 3.85, 3.87).

12. As an adjunct to the existing system of compensation, the proposed enhanced no fault benefits are adequate and represent a substantial and necessary improvement over the current level of benefits (paragraph 3.88).

Threshold

13. Both the Michigan and the New York thresholds represent significant limitations on the existing legal rights of not at fault injured persons. In return for this limitation on legal rights, it would be appropriate to consider enhancing the proposed benefits package by including unlimited medical, rehabilitation and long term care benefits such as are available in Michigan. If this is done, the need for a reinsurance pool along the lines of the Michigan Catastrophic Claims Association must be considered (paragraphs 3.89 - 3.90).

14. So long as the right to sue in tort for excess economic loss remains available, the Board does not consider further amendment to the proposed no fault benefits to be necessary (paragraph 3.91).

Choice No Fault

15. In the context of the choice no fault option, the evidence is that the proposed enhanced no fault benefits do not constitute adequate compensation for economic loss, nor appropriate value for the elimination of the right to sue (paragraph 3.92).

16. If, as a matter of public policy, it is decided to adopt a no fault system -- such as the choice option -- that eliminates or limits significantly the right to recover excess economic loss, consideration should be given to examining and amending the proposed benefits with a view to correcting the deficiencies identified in this Hearing. Generally speaking, the Board considers the amendments proposed by the CAC, particularly those in respect of disability income benefits and indexation, to be roughly appropriate. The Board, however, would support more generous death benefits, as well as unlimited medical, rehabilitation and long term care benefits equal to those available under the Michigan system (paragraph 3.93).

17. In considering the level of recovery under the referred systems, accessibility of benefits is as important as adequacy of benefits: an adequate level of benefits will not assist injured persons if no fault benefits are not easily and quickly available when needed (paragraphs 3.94 - 3.95).

Chapter 4 - Delivery of No Fault Benefits

18. Mr. Justice Osborne's assessment of the insurance industry's performance in delivering existing no fault

benefits as "abysmal" was clearly confirmed by the evidence presented to the Board (paragraphs 4.3 - 4.4).

19. Insurers indicated a willingness to make changes that would improve the delivery of first party benefits. These included the special training of claims personnel, and the establishment of internal procedures to review claims refusals. In addition, they indicated support for ADR and other mechanisms, such as sanctions for late payment, designed to ensure delivery (paragraph 4.9).

20. No fault systems of insurance promise, in return for the extinction or limitation of tort rights, speedy, certain and inexpensive delivery of first party benefits. In light of the evidence concerning the current delivery of no fault benefits, the Board considers it imperative that, prior to implementation of product reform, there should be in place mechanisms to ensure that no fault benefits are in fact delivered in accordance with the insurers' obligations under the contract of insurance. While there is a need even today for such mechanisms within the context of the current add on system of compensation, the need becomes critical if a no fault system is introduced that restricts or precludes access to the courts (paragraph 4.11).

21. An ADR mechanism should be adopted that includes the following features:

(a) The mechanism should be restricted to the resolution of disputes concerning entitlement to and assessment of no fault benefits (paragraph 4.38).

(b) In all cases where the amount in dispute is less than $25,000, non-binding mediation should be available at the option of the insured (paragraph 4.39).

(c) If mediation does not result in settlement of the dispute, arbitration should be available at the option of the insured. Insureds should not be compelled to submit their disputes to arbitration, but rather should have the option to seek resolution of a dispute in court (paragraph 4.40).

(d) Arbitration should be binding. Apart from judicial review, there should be a right of appeal only to a master arbitrator, on limited grounds (paragraph 4.42).

(e) Parties to a dispute should have the right to be represented by counsel, but legal representation should not be a prerequisite to participation in mediation or arbitration proceedings (paragraph 4.43).

(f) In order to facilitate access to no fault benefits by removing cost disincentives, the cost of the ADR system should be borne primarily by insurers. The only costs that claimants should be required to bear are a modest fee upon application for mediation/arbitration and the cost of legal representation, if any. If the mediation results in a settlement in favour of the claimant, or if the plaintiff succeeds at arbitration, the insurer should be required to pay the reasonable legal costs of the insured. An unsuccessful claimant should in no event be responsible for the legal costs of the insurer (paragraph 4.44).

(g) Arbitrators should possess expertise and independence, and should have training to act as arbitrators. Mediators also should have relevant experience and training (paragraph 4.45).

(h) The ADR mechanism should be available across the Province (paragraph 4.46).

(i) The ADR system should recognize the special needs of injured persons requiring rehabilitation (paragraphs 4.47 - 4.48). In particular,

  (i) The decision concerning entitlement to rehabilitation benefits should be made by an independent third party, not the insurer.

  (ii) There should be an independent assessment of the rehabilitation needs of the injured person, performed by professionals with experience in dealing with the type of injury in question.

  (iii) As early access to rehabilitation is essential to the success and cost effectiveness of rehabilitation programs, decisions concerning rehabilitation should be made early.

(iv) Rehabilitation treatment should not await a decision concerning entitlement; the insurer should be required to absorb the expense of rehabilitation pending resolution of any dispute.

22. In order to encourage prompt delivery of no fault benefits, there should be available, in addition to ADR, an enforcement scheme similar to the scheme utilized in New York State. The elements of the scheme should include (paragraphs 4.49 - 4.50):

(a) Specific and precise claims practice procedures. Claims should be required to be paid within a specified number of days.

(b) Substantial interest penalties for late payment of no fault benefits. A penalty of 2 percent per month, the amount charged in New York, would be appropriate in the present financial context.

(c) A requirement that insurers send a prescribed denial of claim form to no fault claimants within a specified time frame, stating clearly the reasons for denial and advising the claimant of the right to seek, and the way to access, mediation/arbitration.

(d) A right in a successful claimant to reimbursement of reasonable legal fees incurred in attempting to secure benefits to which he or she is entitled.

(e) Authority to investigate non-compliance with claims practice requirements, and to impose substantial penalties.

23. The desirability of "bad faith" tort actions should be considered in the event that, even with the implementation of the abovementioned enforcement scheme, current delivery problems persist (paragraph 4.51).

24. The most suitable ADR system for Ontario -- one that would incorporate the essential features outlined in item 21 -- is a system of mediation/arbitration similar to the New York system of no fault dispute resolution, whereby mediation is provided by government at a nominal cost to insureds and arbitration is provided through the

auspices of an agency external to government (paragraph 4.52).

25. The government-administered ADR system should be part of an overall scheme for the enforcement by government of insurer obligations with respect to no fault benefits, incorporating the measures outlined in item 22 (paragraph 4.54).

26. A no fault claims practice division should be established within the appropriate regulatory body, charged with enforcement of no fault benefits delivery. This division should include a mediation section, staffed by employees of the regulator, who should be trained in techniques of mediation and who should attempt to resolve no fault disputes (paragraph 4.55).

27. In order to avoid the creation of a bureaucracy, it would be preferable if arbitration could be administered, under the direction of government, by an outside arbitration agency similar to the American Arbitration Association (AAA), which performs this function in New York (paragraph 4.56).

28. As in New York, the arbitration agency could provide administrative services, hearing rooms, and support

facilities, as well as arbitrators to staff arbitration panels and master arbitrators to hear appeals (paragraph 4.58).

29. Arbitrators should be subject to the approval of a committee comprising representatives of consumers, the insurance industry, the Bar, the arbitration agency, and government. Arbitrators would require special training, which could be provided by the arbitration agency in accordance with government guidelines (paragraph 4.58).

30. To meet the particular requirements of persons requiring rehabilitation treatment, special "fast-track" panels should be set up, on which rehabilitation experts would be represented. These panels should have the power to make an interim award upon the claimant's establishing a _prima facie_ case, on the basis of medical evidence, that rehabilitation treatment is necessary. Every effort should be made to secure the availability of professional consultants with specialized expertise to assist the arbitrator by reviewing medical evidence or examining the injured party and reporting back to the arbitrator (paragraph 4.59).

31. A mechanism of the sort recommended by the Board would result in some of the costs of resolving no fault

disputes being transferred from the public purse, which supports the court system, to insurers, who would fund the ADR system. Depending on the cost efficiencies of ADR, this could result in increased premiums as these costs are passed on to insureds. At the same time, it is the expectation of the Board that ADR would involve some cost advantages that could well offset the costs of an ADR system incurred by insurers (paragraph 4.62).

32. Some guidance as to the general magnitude of the cost of the proposed ADR mechanism is provided by the experience in New York State. The conciliation/arbitration program in that jurisdiction costs in the area of $2.5 million (U.S.), exclusive of legal costs incurred by insurers and insureds. This figure breaks down in the following manner. The cost of the conciliation program is approximately $500,000 (not including cost allocations for overhead), which is covered primarily by fees assessed by the Department. The arbitration program run by the AAA costs approximately $2 million, which is assessed to insurers on the basis of premiums written (paragraphs 4.63 - 4.66).

Chapter 5 - Impact of No Fault Systems on Accident Rates

33. The ongoing debate concerning the effect of abolition of

tort liability on accident rates is advanced, but cannot be resolved finally, by the evidence presented to the Board (paragraph 5.32).

34. The Board accepts Mr. Justice Osborne's conclusions to the effect that the tort system likely exerts some modest deterrent effect on driving behaviour (paragraph 5.33).

35. To the extent that the introduction of a no fault system will result in a levelling of premiums for high and low risk drivers, there will be an increase in the level of driving activity by high risk drivers and a resulting increase in accident frequency. The proposition that no fault systems result in increased accident frequency is supported by a study, conducted by Professor Rose Anne Devlin, concerning the effect on accident rates of the introduction of a pure no fault system in Québec (paragraph 5.34).

36. While the extent of the anticipated increase in accident frequency cannot be quantified, the estimated average prices under the referred systems, as calculated by the Board in Chapter 8, will require adjustment to reflect increased accident frequency (paragraph 5.36).

Chapter 6 - Operational Issues

Overview

37. The Board was not directed in the Reference to determine an appropriate regulatory infrastructure for Ontario. Given the relevance of regulation to the average estimated prices, administrative barriers, costs and price stability, the Board compiled the evidence on the following possible features of regulation: rate regulation; benefit and coverage options; classification; surcharges; consumer information and services; and, contract conversion and timing on implementation. The Board also considered operational matters unique to each of the threshold and choice systems.

38. Product reform alone will not restore the marketplace to a healthy state. It will take commitment to a thorough and continual analysis of the interrelated features of the marketplace over a number of years, as opposed to a single significant one-time reform (paragraph 6.3).

39. The American witnesses used the term "no fault insurance" not only to refer to the product but also to the entire regulatory framework in which the product operates (paragraph 6.4).

Rate Levels Today

40. Ontario private passenger automobile rate levels today are inadequate when measured against costs (paragraphs 6.13 - 6.21).

41. Rate inadequacy in the system could well be in excess of 25 percent industry-wide for the aggregate of all coverages for the period from June 1 to December 31, 1989. Since April 23, 1987, Government mandated increases have been permitted to the extent of 16.5 percent compounded. In the same period, loss costs have increased about 30 percent. The level of inadequacy varies from coverage to coverage. The rates for collision and comprehensive are at least adequate. The coverages for third party liability and accident benefits are inadequate (paragraphs 6.17 - 6.21).

Rate Regulation and Rates on Introduction of No Fault

42. The three most used categories of rate regulation are: file and use; prior approval; and, open market competition. Each of the American jurisdictions studied by the Board uses one or a hybrid of the above-noted models (paragraphs 6.22 - 6.23).

43. Until 1981, rates in Michigan were generally decided by way of a hearing. Currently, companies can use filed rates without approval of the regulator. Rates, however, can be disapproved by the regulator, subject to a hearing, on statutorily defined bases (paragraph 6.24).

44. In New York, a prior approval model was implemented with the inception of no fault insurance as one of the mechanisms to reduce unpredictability, and it remains in use (paragraph 6.25).

45. In New Jersey, a new method of rate regulation was adopted at the same time as implementation of the new no fault system on January 1, 1989. It is a flexible or flex rating model. By law, a maximum average rate will be determined by application of a statutory formula, although the Commissioner may prescribe the allowable increases if the formula would result in excessive rates (paragraph 6.26).

46. At the time of the introduction of no fault in Michigan, rates were not adjusted downward. The amounts being saved through the operation of the verbal threshold were roughly equivalent to the additional cost of the no fault benefits being added. Rates effectively were frozen for a year or two, then allowed to move up (paragraph 6.28).

47. On implementation of its first threshold in 1974, the New York State Legislature mandated that rates be rolled back by 16%. Although it was disputed whether this was actuarially justified or whether it was done to help "sell" the restriction on lawsuits, New York rates are maintained at an adequate level (paragraph 6.30).

48. New Jersey's original no fault law took effect on January 1, 1973 based on a monetary threshold. A 15% reduction in rates for new and renewal business after the effective date was mandated at that time. In the opinion of most witnesses before the Board, rates were inadequate in New Jersey before the 15% reduction, with the result that the reduction exacerbated the problem. It is a problem that exists to this day and a prime reason for the crisis in New Jersey (paragraphs 6.31 - 6.34).

49. In the United States it appears that the greater the degree of uncertainty about prices in no fault, the more attractive rate regulation becomes to the regulator and, in some circumstances, to the regulated. There is, however, no necessary correlation between no fault compensation and any particular form of rate regulation (paragraphs 6.36 - 6.37).

50. Whether the system of rate regulation produces rate

adequacy, however, is related to whether no fault was promoted as a means of lowering premiums. Michigan is perhaps the best American example of a state that moved to no fault in order to improve benefits, and rate adequacy has been maintained. The New York regulators have a commitment to keeping rates adequate, although to date there has not been any real tension between the rate level required to achieve adequacy and the political acceptability of that level. In New Jersey, regulatory action has placed downward pressure on rates over a number of years. As a result, the crisis in automobile insurance in that State remains (paragraphs 6.38 - 6.40).

51. If a decision is made in Ontario to move to a regulatory model which has prior approval on a company by company application basis, and at the same time the rates going into the new system are inadequate by some measure, it is forseeable that a significant "bottleneck" could occur in the rate approval process and that bottleneck would undoubtedly have ramifications for consumers in that tight conditions in the marketplace would continue to prevail (paragraphs 6.41 - 6.42).

Benefit and Coverage Options

52. Under mandatory coverages for no fault, at least two

groups will be paying, to some extent, for accident benefits which they can never receive. There are those who may not be able to meet the eligibility requirements, and those who already have coverage through other insurance contracts. These insureds subsidize others. This problem exists today, but will be magnified in any of the referred systems except choice tort because there will be a significant increase in the accident benefit benchmark premium from today's levels (paragraphs 6.44 - 6.50).

53. Different classification variables, buying down of coverages, discounting and coordination of benefits are remedies to cross subsidization in accident benefits. Also, they would assist consumers in lowering premiums to themselves where their personal circumstances justify it. The Government should consider these remedies (paragraphs 6.52 - 6.61).

54. Increasing certain benefits at the option of an insured also should be considered (paragraphs 6.62 - 6.64).

55. There may be a conflict between consumers' preferences for a flexible insurance product and the confusion which could result from too many options. Comprehensive consumer education can assist consumers in making

personal decisions about automobile insurance and the options should be restricted to the most useful ones (paragraphs 6.65 - 6.73).

56. The average estimated prices under the referred systems in the Reference do not incorporate the costs which would flow from optional coverages or benefit levels in excess of those included in the referred systems, or from periodic revision of the base benefits to keep pace with inflation. The quantification of such costs must await the details of the product (paragraphs 6.65 - 6.66, 6.75 - 6.76).

Classification

57. If rates are to be set or monitored on some industry-wide basis, the Board is of the view that uniformity in classification, rating methodology and differentials is essential. If, however, rates are to be set on a company by company basis subject to some over-riding approval or disapproval power, uniformity is not essential for purposes of rate regulation. The regulatory authority, however, will have to develop approaches which allow insureds of different companies to satisfy themselves that there is equity (paragraphs 6.77 - 6.78).

58. The consumer must be able to understand the basis on which the price he or she is to be charged is calculated. The consumer must also be able to make meaningful comparisons among the prices to be charged for a similar product by competing insurers (paragraphs 6.79 - 6.80).

Surcharges

59. Today, surcharges are designed to reflect the possibility that any particular driver will incur at fault claims in the rating period. Surcharges are an imperfect measure of risk propensity. The Board accepts that a better vehicle for measuring risk for rating purposes does not appear to have been developed and used in the industry (paragraphs 6.85 - 6.97).

60. Consumers strongly favour the use of surcharges, although surcharges can make automobile insurance expensive for those who must pay (paragraphs 6.98 - 6.103).

61. While support for surcharges from insurers and consumers does not appear to have been based on a deterrent function, surcharges may be the only readily available mechanism in the insurance industry to counter-balance, to some degree, the effect that introduction of a no fault system will have on the decision of high risk

drivers to drive at all, and on the driving behaviour of certain individuals (paragraph 6.104).

62. Insurers have various methods of determining fault which generate administrative and legal expenses. About 97% of claims are settled, although the few which are decided in court do influence all of the others and this may be difficult to replicate in a no fault system (paragraphs 6.105 - 6.110).

63. In the referred systems, the greatest proportion of payouts will be made regardless of fault. In fact, if the industry is unregulated, there will be competitive pressure to use surcharges based on payouts. If the Government decides to retain the use of surcharges because they serve a deterrence function, and if it is decided that they should not be based on payouts, it should be recognized that there will be less incentive to determine fault and a degree of inexactitude in the end result. Standards therefore are advisable (paragraphs 6.111 - 6.125).

64. If surcharges are retained, costs will continue to be expended on fault investigations for rating purposes, although not necessarily for claim purposes. In the Board's view, it is possible to have some savings in

these administrative and legal costs in the referred systems while maintaining a surcharge system (paragraphs 6.126 - 6.128).

65. Moving from a fault system to no fault system may necessitate mandating that only at fault accidents be surcharged and that not at fault accidents not be surcharged (paragraphs 6.129 - 6.130).

66. The increased reliance on the insurer to determine fault in a no fault environment will necessitate a dispute or appeal mechanism for use by insureds who may wish to challenge the application of a surcharge. Such a mechanism is in place in Michigan (paragraphs 6.131 - 6.132).

Consumer Information and Services

67. In the Board's view, the success of implementation of a new product will depend almost entirely on having a system of consumer information and services in place before the implementation date. Product and price information are essential. As well, any new services available to consumers (for example, an alternate dispute resolution mechanism for first party benefits) will only be of benefit to consumers if they are instructed on how

to use them (paragraphs 6.134 - 6.143).

68. Given the Board's experience in recent months with consumer telephone calls and correspondence, arrangements must be made for the establishment of an adequate consumer information and inquiry service (paragraph 6.142).

69. Product reform will require amendments to a number of standard forms in use today for private passenger automobile insurance. Consideration must be given to whether, and when, insureds should be provided with new documents (paragraph 6.141).

70. Adding the necessary consumer information and services to the system cannot be done without cost (paragraphs 6.144 - 6.145).

Interpretation of Verbal Thresholds

71. Understanding automobile insurance is difficult, and understanding a system incorporating a verbal threshold is not an exception to the rule. It will represent a significant change from today's product and consumers will want to appreciate its implications for their own plans (paragraphs 6.148 - 6.151).

72. It is a characteristic of every verbal threshold that it will not always be clear whether a specific injury passes or fails the threshold. As a result, the Government may wish to consider whether, through the rules of civil procedure or some other appropriate vehicle, a relatively speedy means of resolving whether a claim passes the threshold could be put in place, as in New York (paragraphs 6.152 - 6.155).

73. Erosion of the cost savings arising from a verbal threshold can arise through the claims settlement process if, in order to settle claims more quickly, insurers make inflated payments for non-economic losses. Erosion also can arise through judicial interpretation (paragraphs 6.156 - 6.157).

74. In the Board's view, the possibility of erosion of a threshold cannot be ignored and if the Government prefers a verbal threshold, serious consideration should be given to contemporaneous implementation of measures designed to contain it. In particular, consideration should be given to providing by legislation that interpretation of the threshold is a matter of law, which should be dealt with by a judge (paragraphs 6.158 - 6.161).

Choice Option

75. Apart from the Industry Coalition and certain insurers, there was no support for the choice option. Even the Industry Coalition's and insurers' support was qualified in that they preferred a pure no fault option (paragraphs 6.166 - 6.167).

76. The structure of the choice option requires that the named insured make the choice, based on what might happen in the future, with respect to liability rules and benefits for himself or herself, as well as all dependants (including spouses) as defined in the Reference. This will present practical problems in administration, and it may be challenged at law. Also, different choices can be made for different automobiles owned by the named insured, a probable source of administrative difficulty for brokers and of consumer confusion (paragraphs 6.168 - 6.173).

77. It will be difficult for any consumer to have a complete understanding of all of the ramifications of the choice option. A major commitment of materials and broker/agent time must be available to consumers to ensure any reasonable degree of understanding and acceptance (paragraphs 6.174 - 6.181).

78. The Insurance Brokers Association of Ontario (IBAO) suggested that brokers would be faced with an "impossible task" in meeting their duties to clients under the choice option. The only remedy which the brokers saw to this situation was the need for a statutory procedure, including a signed declaration which, if followed, would guarantee brokers immunity from legal action for a breach of the standard care owed, at law, to customers (paragraphs 6.182 - 6.184).

79. The administrative pressures which occurred in New Jersey and which could be duplicated in Ontario with respect to the introduction of choice would make this option costly for brokers to deliver. In fact, it will be difficult for brokers to have time to service each consumer sufficiently (paragraphs 6.185 - 6.191).

80. In New Jersey brokers are afforded a degree of protection in the delivery of the choice option. Testimony before the Board indicates that statutory protection is indicative of the magnitude of the problems which would be created in the delivery and administration of the choice option. In the Board's view, however, this form of protection is over-inclusive and cannot be justified on the basis of the evidence in this Hearing. If a statutory protection is to be given, the scope of the

provisions should be reconsidered (paragraphs 6.192 - 6.201).

81. Determining whether both options in choice are properly priced is the single most difficult, and potentially the most serious, question about choice. Firm predictions cannot be drawn at this point because of the number of unknowns. The critical factor is how high risk drivers will be distributed between the tort and pure no fault pools. Over time, it is likely that high risk drivers will cause the rates for choice no fault to migrate upward, and the rates for choice tort to migrate downward. Surcharges can be used, but it cannot be predicted whether they will function to balance the two pools (paragraphs 6.202 - 6.215).

82. It is likely that, in the first two or three years of the operation of choice, people with lower salaries will select pure no fault, while people with higher salaries will select tort (paragraphs 6.216 - 6.219).

83. The elimination of subrogation in a choice system will frustrate proper rating of drivers and will result in increased premiums for long term disability insurance (paragraphs 6.220 - 6.224).

84. In the Board's view, the possibility of consumers being steered by insurance companies and brokers to either tort or no fault is real, particularly if there is rate inadequacy in either (paragraphs 6.225 - 6.229).

85. The administrative cost implications in the choice option could be substantial because of the need for maintaining dual systems (paragraphs 6.230 - 6.233).

86. The litigating of fault in a first party format as required in the choice tort option will be a source of real concern and frustration to insureds in that system. Consideration should be given to whether insurers will have a conflict of interest that can be resolved only by a system of independent investigation and legal advice (paragraphs 6.234 - 6.237).

87. Whether the implementation of a reinsurance pool is required must be addressed (paragraphs 6.238 - 6.240).

Conversion of Contracts and Timing

88. It is unclear whether all in force contracts will be amended on the same effective date or whether new contracts will be issued on a renewal basis over a year.

Either approach has difficulties (paragraphs 6.241 - 6.247).

89. On the introduction of a new product, insurers could experience cash flow problems with the result that presently under-reserved companies could face insolvency (paragraphs 6.248 - 6.249).

90. In the Board's view, the industry transition time estimates, with the exception of that of the IBAO, do not sufficiently account for the educational demands of transition. With respect to transition times the Board finds:

- if the regulatory scheme in the Act is maintained, necessitating public hearings on both industry-wide classification and rates, a threshold system could not be implemented in less than nine months from the date the statutory provisions are fully known because education time must be allowed following the decisions in the hearings;
- if the regulatory scheme is changed, and in particular if companies are largely unregulated as to classification and rates (i.e., no prior regulatory approval of rates), a threshold system could be implemented in an absolute minimum of six months from the date the statutory provisions are fully known, allowing sufficient time to educate consumers and allowing them to order their affairs, although this would place a strain on the distribution system and service levels; and,
- choice should not be implemented in less than one year from the date the statutory provisions are fully known, and could not be implemented

in a lesser period if public hearings on classification and rates are required in addition to adequate education time.

(paragraphs 6.250 - 6.261)

OHIP Utilization

91. Product reform on the basis of the referred systems will increase OHIP costs. These costs could be funded by OHIP itself or by insurers through the bulk subrogation agreement which would require revision (paragraphs 6.262 - 6.272).

Growth in Rehabilitation and Long Term Care Services

92. There is a firm possibility that no fault insurance could result in growth of rehabilitation and long term care services. This in turn raises the question as to the degree to which pressures might arise to regulate and fund rehabilitation and long term care services on a different basis than today (paragraphs 6.273 -6.282).

Utilization of Public Income Support Plans

93. There may be some increase in utilization of public income support plans under no fault compared to the

present tort system. On balance, however, it would appear that the cost to taxpayers generally will not significantly increase as a result of the change in the automobile insurance product (paragraphs 6.283 - 6.289).

General Comments on Administrative Barriers

94. In the Board's view the evidence indicates that there are no true administrative barriers with respect to the implementation or ongoing operation of a verbal threshold system (paragraph 6.290).

95. Significant lead time and substantially more resources from the public and the private sectors will be required to overcome the more serious impediments to a choice system (paragraph 6.291).

96. There are 13 principal underestimated or excluded costs which, depending on the approach taken by the Government, could affect the average estimated prices of each of the referred systems on implementation (paragraph 6.294).

97. There are 10 principal underestimated or excluded costs which, depending on the approach taken by the Government, could affect the average estimated prices on an ongoing basis (paragraph 6.295).

Chapter 7 - Price Stability

98. The following items play an important role in determining the level of price stability in any period and they relate to each other in a dynamic way:

- frequency and severity of loss
- operating expenses
- the uncertainty in estimation which arises from the need to price prospectively
- competition among insurers
- general economic conditions
- nature and extent of regulation

(paragraphs 7.1 - 7.19).

99. The Board draws the following conclusions from the U.S. evidence with respect to price stability:

1) Over time, private passenger automobile insurance premiums in the U.S. threshold states do not move downward or stay flat but are moving in an upward direction as in Ontario.

2) There is no proof that price increases in threshold no fault states are more moderate

than in other states. At best, comparing groups of states with similar products, the increases over time are more or less equivalent.

3) There is evidence that price increases in threshold no fault systems can be significantly greater than in states with other types of products, but the possible reasons for this are many, and can vary from state to state.

4) Over the long term, comparing the various threshold no fault systems, each of them results in similar percentage increases. Interestingly, price increases in New York have been below the national average and more stable over the last 5 years, while those in Michigan have been slightly above the national average and less stable.

5) Some opinion evidence was given with respect to Michigan to the effect that price increases would have been less stable if the tort system had been retained.

6) There was evidence as to what might contribute to increased price stability:

- rate adequacy for the benefits provided;
- controls on the charges for products and services related to the benefits, e.g. medical fees; and,
- claim severity becoming less a function of socio-economic factors, as in tort awards, and more a function of economic indices, thereby reducing "social inflation", with the result that the value of claims is easier to predict.

(paragraphs 7.20 - 7.21)

100. There are two fundamental conclusions which apply to each of the referred systems. First, costs in any given period, may not be dominant in determining prices because of the dynamic factors at play. Second, rate stability should not be understood to mean flat prices. The question is whether price increases will be stable.

101. The Board concludes that, assuming insurers are unrestricted in rate setting and assuming no new regulatory measure of dramatic effect, in a verbal threshold system there is likely to be instability in average estimated prices in the short term (one to three years) (paragraph 7.24).

102. Unless the form of rate setting is industry-wide, rate regulation will be of limited effectiveness in increasing rate stability (paragraph 7.25).

103. Without the liberty to move to rate adequacy or a rate regulatory system which promises movement to rate adequacy within a defined time frame, rate inadequacy will be the most serious impediment to reaching rate stability (paragraph 7.26).

104. Over the mid to long term rate stability will be more influenced by the combined effect of calibrations to the system to assist it in functioning efficiently than by the existence of a verbal threshold itself (paragraph 7.27).

105. With respect to the choice system, the dominant feature determining rate stability will be the composition of the tort and no fault pools from time to time and, as the system currently is structured, that composition is unstable which does not allow any useful predictions about rate stability to be made (paragraphs 7.28 - 7.29).

Chapter 8 - Estimated Average Prices

Limitations

106. The terms of the Reference were not sufficiently particular to make it possible for the Board to fulfil its mandate without making a great number of very important assumptions. Therefore, a common set of assumptions for the use of all parties in preparation of the cost estimates was made. If one of the proposed systems were to be implemented in a form that involved a change in the assumptions used by the Board, then the cost estimates could be significantly different. If the Government brought in a different product than those set out in the Reference, then different assumptions for that product would have to be made (paragraphs 8.5 - 8.6).

107. The calculation of premium levels and savings applies only to the specific proposals before the Board (paragraph 8.7).

108. The cost estimates are an attempt to cost a new system of insurance and such an exercise is an attempt to predict the future. American statistics are available, but comparable Ontario statistics are not. Caution is advised with respect to putting too great an emphasis

upon U.S. experience (paragraphs 8.8 - 8.16, 8.30).

109. Not all aspects of the potential costs of the proposed systems can be quantified (paragraph 8.21).

110. Any cost savings forecast arise almost entirely from a reduction in benefits payable to injured claimants (paragraph 8.22).

111. Any percentage savings due to the introduction of no fault are one-time savings only. After the implementation of any new system of insurance, loss costs, and hence premiums, will continue to rise at levels at least equal to those that would exist under the current system, all other things being equal (paragraph 8.23).

Effective Period

112. If the Government is unable to legislate and implement product reform in its target time frame (December 31, 1989), then premiums will have to be adjusted to reflect the current annual loss cost trend of approximately 10% (paragraph 8.34).

Accident Frequency

113. The Board is of the opinion that the proposed systems, and in particular the choice system, will result in an increased accident frequency (paragraphs 8.42 - 8.43).

Utilization

114. There will be an increase in the utilization rates of no fault benefits. The greater the restriction on tort remedies, the greater will be the utilization of the no fault remedies (paragraphs 8.44 - 8.56).

115. The increased utilization for medical, rehabilitation and long term care benefits is 50% for the two threshold proposals and 75% for choice no fault (paragraphs 8.50 - 8.53).

116. The increase in the utilization of disability income benefits for the threshold systems is 25% for all classes of beneficiaries other than those not previously covered and 35% for choice no fault (paragraphs 8.54 - 8.55).

117. The number of claimants for unpaid housekeeper benefits is 75% of the number of wage earners (paragraph 8.56).

Residual Bodily Injury

118. With respect to liability coverage for accidents involving claimants outside the system, the Board finds 16% of loss costs appropriate for the threshold options and 20% of loss costs for choice no fault (paragraphs 8.57 - 8.61).

Interest Rate

119. An 8% interest rate is appropriate (paragraph 8.62).

Indexation of Benefits

120. An index rate of 5% is appropriate (paragraph 8.63).

OHIP

121. The Board bases its calculations on the premise that OHIP will continue to receive the current dollar value of approximately $46,000,000 per annum from the auto insurance premiums paid in this Province (paragraphs 8.64 - 8.67).

Excess Economic Loss

122. The Board assumes that all claimants who meet the threshold will recover 100% of their economic loss. The Board further assumes that of the claimants who do not meet the threshold, half of those earning over $450 per week will recover 100% of their economic loss and the remainder will recover 80% of their gross wage to a maximum of $450; all of those earning under $450 will recover 80% of their economic loss (paragraphs 8.68 - 8.70).

Effectiveness of the Threshold

123. The most material assumption to the estimation of average prices of the two threshold systems is the calculation of the proportion of claimants who fail to meet the threshold. The Board finds that for Option 1 (Michigan), 15% of claimants would pass the threshold. With respect to Option 2 (New York), 33% would pass the threshold (paragraphs 8.71 - 8.93).

Conclusions

124. Excluding the change in accident frequency arising from the introduction of a no fault system, the Board finds

the changes from benchmark rates to be as follows:

OPTION	ESTIMATED CHANGE IN BENCHMARK RATES AT 0% INCREASED ACCIDENT FREQUENCY
Option 1 (Michigan)	- 6.0%
Option 2 (New York)	- 0.3%
Option 3	
- Choice Tort	+ 2.2%
- Choice No Fault	-23.1%

(paragraphs 8.94 - 8.95).

125. The Board recognizes that the amount of the increased accident frequency arising from the introduction of a no fault system is very difficult to estimate. The increase cannot be realistically determined until product reform has been implemented for several years. Thus, the projected savings, which do not include an adjustment for increased accident frequency, are too optimistic. Although an increase in accident frequency will not apply equally across all options, the estimated cost changes reflecting changes in accident frequency of +5% and +10% are provided for illustrative purposes as follows:

OPTION	ESTIMATED CHANGE IN BENCHMARK RATES AT INCREASED ACCIDENT FREQUENCIES OF:	
	+ 5%	+10%
Option 1	- 2.0%	+ 2.0%
Option 2	+ 4.0%	+ 8.3%
Option 3		
- Choice Tort	+ 6.6%	+11.0%
- Choice No Fault	-20.0%	-16.9%

(paragraph 8.96)

Chapter 9 - Extension to Other Vehicles

Threshold Systems

126. It is feasible to extend the no fault threshold systems to vehicles other than private passenger automobiles (paragraphs 9.5 - 9.6).

127. There should be general rules that:

- No fault coverage follows the car a passenger-victim occupies.

- A pedestrian-victim looks to the car that hit the pedestrian.

(paragraph 9.7)

128. An exception to the general rules should be made for buses; namely, that victims with auto insurance policies should look to their own insurers (paragraph 9.7).

129. With respect to taxis and limousines the incentive to develop risk management programs be reduced if no fault benefits were to be paid by other insurance policies. Therefore the right of subrogation for the first party benefits should be permitted where the accident involves a taxi or limousine (paragraphs 9.8, 9.11).

130. With respect to commercial vehicles, the major concern is that heavy commercial vehicles are "loss causers". There should therefore be a right of subrogation with respect to these vehicles (paragraphs 9.9 - 9.11).

131. The Board finds that motorcycles should be included in a threshold system subject to a right of subrogation for the first party benefits (paragraphs 9.13 - 9.16).

132. The Board finds that a threshold system could be extended to all other personal vehicles (paragraph 9.17).

Choice System

133. With respect to the choice system, the Board finds that it is not feasible to extend this system to public and commercial vehicles, and in the personal vehicles category, to motorcycles, motorized snow vehicles, and off-road vehicles (paragraphs 9.18 - 9.22).

134. The Board concludes that the choice system could be extended to include trailer and camper units, motor homes and historic vehicles (paragraphs 9.23).

TABLE OF CONTENTS

Page

1. INTRODUCTION 1

A. The Requirements of the Reference 1

B. Essential Background to the Reference 3

1. Consumer Concerns 3

2. Understanding the Difference Between Compensation and Funding 7

3. The Choice Model 12

C. The Options in the Reference 14

D. The Scope of the Reference 17

1. Threshold Definitions 17

2. Contractual Provisions 19

3. Regulatory Infrastructure 20

4. Distribution of Costs Arising from Automobile Accidents 21

5. Accident Frequency and Severity 23

6. Alternatives to Threshold and Choice 23

E. Participation of the Parties 26

F. Role of the Board 27

2. THE HEARING 29

A. Notice of Hearing 29

B. The Pre-Hearing Conferences 29

C. Board Consultants 30

D. The Hearing 33

E. The Report 34

3. LEVEL OF RECOVERY 35

A. Introduction 35

B. Justification for No Fault Systems 38

1. Background Considerations 38

(a) Affordability 38

(b) Traditional Rationale for No Fault Systems 40

(c) The Proposed Enhanced No Fault Benefits 42

2. Merits of Existing and No Fault Systems 45

(a) Equity Considerations 47

(1) Restrictions on Levels of Recovery 47
(i) Threshold Systems 47
(ii) Choice No Fault System 57

(2) Fault vs. Need; Economic vs. Non-Economic Loss 61

(b) "Efficiency" Considerations 67

(c) Price Considerations 76

3. Conclusions 79

C. Adequacy of Enhanced No Fault Benefits 84

1. General Level of Adequacy 85

(a) Income Disability Benefits 85

(1) Econanalysis 85

(2) Other Comments 88

(b) Death Benefits 88

(c) Medical and Rehabilitation Benefits 89

(d) Long Term Care Benefits 89

(e) Replacement Services 90

(f) Indexation 90

2. Adequacy Under the Referred Systems 90

3. Conclusions 92

D. Accessibility of No Fault Benefits 96

4. DELIVERY OF NO FAULT BENEFITS 98

A. Introduction 98

B. Delivery of Existing No Fault Benefits 98

C. Alternative Dispute Resolution 103

1. Introduction 103

2. Potential ADR Models 105

(a) The Arbitrators' Institute of Canada Plan 106

(b) New York Conciliation/Arbitration Program 111

3. Essential Features of an ADR Mechanism 116

D. Additional Delivery Mechanisms 125

E. Conclusions 129

F. Cost Impact of ADR 133

5. IMPACT OF NO FAULT SCHEMES ON ACCIDENT RATES 137

A. Introduction 137

B. Impact of Change in Liability Rules 140

1. Standard of Care 141

2. Level of Driving Activity 144

3. Empirical Evidence 147

C. Conclusions 154

6. OPERATIONAL ISSUES 158

A. Introduction 158

B. The Key: Determining What is Essential 161

C. Rate Levels in Ontario Today 163

D. Rate Regulation 170

- 1. General Models 170
- 2. Selected American Jurisdictions 171
- 3. Ontario Insurers' Position 178
- 4. Commentary 178
  - (a) Importance of Attitude to Cost 178
  - (b) Resource Considerations 182
  - (c) Who should have the Burden? 183

E. Rating Implications of No Fault Benefits and Coverage Options 184

- 1. Pricing for the Average 184
- 2. Utilization of No Fault Benefits 185
- 3. Looking at the Referred Systems 186
- 4. Remedial Approaches to Cross Subsidization and Duplicate Benefits 190
  - (a) Possible Classification Variables 191
  - (b) Discounting 192
  - (c) Buying Down or Opting Out of Mandatory Coverages 192
  - (d) Coordination of Benefit Plans 193
- 5. Benefit Options 197
- 6. Revision of Benefit Levels 198
- 7. Commentary 200

F. Regulation of Classifications, Rating Methodology and Differentials 205

- 1. Rate Regulation and Uniformity 205

2. Consumer Interests 206

G. Surcharges 208

1. Purpose 209

(a) Risk and Predictability 209

(b) Consumer Views 216

(c) Deterrence 218

2. Administrative Consideration 218

(a) Methods of Determining Fault Today 218

(b) Determining Fault in the Referred Systems 221

(c) Data Availability and Equity 224

(d) Costs 227

(e) Regulation of Surcharges 229

(f) Surcharge Appeal Procedures 230

3. Commentary 232

H. Consumer Information and Services 233

1. Introduction 233

2. Components 234

3. The Realities: Time and Money 238

I. Operational Matters Specific to the Threshold Options 239

1. The Role of Interpretation 239

2. Consumer Understanding and Acceptance 240

(a) Overall Awareness 240

(b) Advising Claimants and Disincentives to Sue 242

3. Erosion in Cost Savings Attributable to Interpretation 244

4. Other Cost Implications 249

J. Operational Matters Specific to the Choice Option 250

1. Lack of Support for Choice 250

2. The Challenges Presented to Consumers 252

(a) The Nature of the Decision 252

(b) Understandability 255

3. The Challenges Presented to Brokers 261

(a) Duties of Brokers 261

(b) Administrative Pressures 263

(c) Statutory Protection 266

4. Factors Influencing Consumer Choice 273

(a) Rating and Adverse Selection 273

(1) Introduction 273

(2) Treatment of the High Risk Driver 275

(3) Income Level 281

(4) Subrogation 282

(b) Steering 284

5. Other Cost Implications 286

(a) Need for Dual Systems 286

(b) Litigating Fault in a First Party Format 288

(c) Reinsurance 290

K. Conversion: How and When 291

1. Contract Considerations 291

2. Insurer Cash Flow 295

3. Transition Time 296

L. Costs Relationship Between Automobile Insurance and Other Payment Schemes 301

1. OHIP Utilization 301

2. Growth in Rehabilitation and Long Term Care Services 304

3. Utilization of Public Income Support Plans 308

M. Overview of Administrative Barriers and Cost Implications 312

1. Administrative Barriers 312

2. Cost Implications 314

7. PRICE STABILITY 317

A. Scope of the Question 317

B. Dynamic Forces Determining Stability 318

1. Frequency and Severity of Losses 318

2. Operating Expenses 320

3. Prospective Pricing 321

4. Competition Among Insurers 321

5. General Economic Conditions 322

6. Nature and Extent of Regulation 322

C. Price Stability in Ontario Prior to April 23, 1987 323

D. Conclusions Drawn From Experience in U.S. Pertaining to Threshold No Fault States 325

E. Conclusions Pertaining to the Referred Systems 329

1. Threshold Options 329

2. Choice Option 331

8. ESTIMATED AVERAGE PRICES 333

A. Introduction 333

        1. Limitations of the Cost Estimates 334
            (a) Assumptions 334
            (b) Appropriateness of Statistics 337
            (c) Prices and Dislocation 341
            (d) Company Circumstances 342
            (e) Regulation 343
            (f) Other Costs 343
            (g) Future Price Increases 345
        2. The Conclusions of the Actuaries 345
    B. Data 347
    C. Benchmark Rate 349
    D. Effective Period 351
    E. Profit 352
    F. Selection Between Choice Options 353
    G. Accident Frequency 356
    H. Utilization 357
        1. Medical and Rehabilitation Benefits 359
        2. Disability Income Benefits 362
        3. Unpaid Housekeeper Benefits 362
    I. Residual Bodily Injury 363
    J. Interest Rate 367
    K. Indexation of Benefits 367
    L. OHIP 367
    M. Excess Economic Loss 369
    N. Effectiveness of the Threshold 370
    O. Conclusions 381

9. EXTENSION TO OTHER VEHICLES 384
    A. Introduction 384
    B. Feasibility 385
    C. The Threshold Systems 385
        1. Public and Commercial Vehicles 386
        2. Motorcycles 390
        3. Other Personal Vehicles 392
    D. The Choice System 393
        1. Public and Commercial Vehicles 393
        2. Motorcycles 394
        3. Other Personal Vehicles 395

APPENDICES

A. Order in Council dated March 2, 1989

B. List of the Persons Served with Notice of Hearing; List of Newspapers in which Notice of Hearing was published

C. Notice of Hearing dated March 9, 1989; Procedural Order - 1 dated April 7, 1989

D. List of Parties who appeared, the Limited Intervenors, and the Witnesses

E. Index to the Transcripts

1. INTRODUCTION

A. THE REQUIREMENTS OF THE REFERENCE

1.1 The Ontario Automobile Insurance Board (the Board) was directed by the Lieutenant Governor in Council, by Order in Council dated March 2, 1989 (the Reference), to hold a public hearing on the matters specified in the Reference. Such a reference is authorized by section 28 of the Ontario Automobile Insurance Board Act, 1988, S.O. 1988, c.18 (the Act). The full text of the Reference is included as Appendix A.

1.2 The Board is confined to the mandate given to it in the Act. In the case of a reference, the obligation of the Board is to perform the tasks stated in the reference, subject to any procedural directions which are included in the reference or which flow from requirements otherwise, at law, applicable to the Board.

1.3 The Reference ordered that a public hearing be conducted to examine a threshold no fault system of privately delivered automobile insurance (with two, alternative, verbal thresholds specified) and a choice system (with alternative tort and no fault options) of privately delivered automobile insurance. These systems will be introduced in greater detail below. The Board is not directed, however, to report on any or all aspects of these systems, but instead is specifically directed to report on the following matters:

- An estimation of the average prices that would be charged for automobile insurance policies within the referred systems based on the mandatory classification system (the Board Class Plan), the determinations of facts and rates established by the Board under its Decision dated February 13, 1989, under File No. I-88-1D (Decision I-88-1D);
- The feasibility of extending the systems to public and commercial vehicles;
- The cost impact, if any, of the implementation of an alternative dispute resolution mechanism involving mediation and, if necessary, binding arbitration, for the settlement of no-fault compensation;
- The administrative barriers that exist in relation to the systems that could result in significant additional costs either in implementation or in the continuing operation of the systems;
- Whether there would be greater stability in the average prices charged for automobile insurance policies after implementation of the systems; and,
- An estimation of the level of recovery to injured persons that would be achieved under the systems.

1.4 The Board understood, interpreting the Reference as a whole, that the referred systems were intended to apply only to private passenger automobiles (which constitute the major part of the Personal Vehicles category under the Board Class Plan). In order to resolve a lacuna in the Reference, therefore, the Board expanded the second issue -- feasibility of extending the systems -- to include the category of Personal Vehicles other than private passenger automobiles (i.e., to include motorcycles, trailers and camper units, motor homes, motorized snow vehicles, off-road vehicles, and historic vehicles).

- Pre-Hearing Conference, April 7, 1989; Transcript, at 126, 187-91

1.5 The Reference ordered that the Board commence its public hearing and report to the Lieutenant Governor in Council as soon as is practical.

B. ESSENTIAL BACKGROUND TO THE REFERENCE

1. Consumer Concerns

1.6 It cannot be disputed, nor was it disputed at the Hearing, that the cost of private passenger automobile insurance is a matter of concern to many of the approximately six million drivers in Ontario. Indeed, Ontario consumers have this concern in common with many others in Canada and the United States. A 1985 report from the U.S. Department of Transportation puts the reality neatly (Exhibit 14.6, at 67):

> The average motorist seems to regard cost as the only really important criterion of the effectiveness of an auto insurance system. This attitude is a consequence of one of the salient characteristics of personal injury auto insurance: while motorists pay premiums once or twice a year, they can realistically only expect to receive benefits once or twice in 20 years (when they have an auto accident with personal injury). This characteristic heightens the motorist/voter's sensitivity to insurance benefits. The fact that the purchase of auto insurance is in many cases involuntary ... accentuates the motorist's sensitivity to the cost.

1.7 The Board, particularly in Part 4 of the Industry-Wide Hearing, heard from many drivers about their cost concerns. The question of affordability was frequently raised, especially by those on fixed incomes or at the lower end of the earning scale. As discussed in the Decision with Reasons I-88-1D (Personal Vehicles - Private Passenger Automobile Insurance Rates), the Board is directed by statute to set rates which are just and reasonable and not excessive or inadequate. Although the Board could not set rates by a standard of affordability, general affordability was considered in balancing the interests of those affected by automobile insurance rates. The Board does not have available to it any quantitive measure, or even any qualitative analysis, of the affordability problem. Mr. Justice Osborne stated the following on this subject (Exhibit 13.6.1, Osborne Inquiry Report, at 513):

> I approach the affordability issue somewhat cautiously. I take it no further than to state that because automobile insurance is compulsory, it must be made available at a price consistent with sound insurance principles. I do not think it is appropriate to impose an obligation on the government or on the private sector to make automobile insurance affordable to all, particularly those drivers who by their conduct deserve to pay high premiums. Automobile insurance is compulsory, driving is not.

The evidence in this Hearing does not throw any more light on the subject, and the views of the participants varied as to whether the affordability concern was well-founded in light of the limits and benefits in place in Ontario. The perception certainly was not challenged. The Board was not requested in the Reference to report on the affordability of any insurance products and therefore does not address that subject.

1.8 It will be clear from the summary of public comments contained in Chapter 4 of Decision I-88-1D, however, that consumers have a wide range of concerns, relating to loss costs, cost controls, profitability of insurers, role of brokers, classification, rating, underwriting and, in general, to the market conduct of insurers. Many of these concerns were repeated in various ways at this Hearing.

1.9 The Board, primarily through the efforts of two parties and a limited intervenor -- Advocacy Resource Centre for the Handicapped (ARCH), Fair Access to Insurance Reform (FAIR) and Better Auto Accident Treatment for Injured Victims in Ontario (BATT FIVE) -- heard extensive evidence from those who have been injured, from those whose lives have been touched and in many cases altered by involvement in automobile accidents, and from those who deal with the aftermath of injury and involvement. Such evidence gave a clear indication that many people in this Province are concerned about the benefits available through automobile insurance, although often it takes an injury producing accident to shift the concern from the cost of insurance to benefits received. The Board heard evidence, for example, from Mrs. Nancy Fowler whose husband received a closed head injury in July 1983 from which he has never recovered consciousness (Transcript, at 5491):

> I believe that people are concerned about the cost ... But until they're involved in an accident and they require financial assistance, then -- I think you have to be involved in something. Everybody thinks, 'Oh, it's going to cost less money', but they don't realize just what's behind all of that.

1.10 The major conclusion which the Board draws from such comments and evidence is that consumers do not have a single interest in automobile insurance, but in fact have a range of interests which vary depending on their particular circumstances and needs. It is a strongly held view of the Board, based on the evidence it heard, that any insurance system for private passenger automobiles must be responsive to the various needs of consumers. Cost concerns may be at the heart of the Reference, but any public policy perspective based solely on cost concerns will not respond to consumer needs.

2. Understanding the Difference Between Compensation and Funding

1.11 In Ontario currently, the compensation of victims of automobile accidents is anchored by general "tort" principles which have developed, at common law and as modified by statute, over centuries. Essentially, if an individual can prove that he or she suffered a loss through the fault, or negligence, of another (the tortfeasor), then that individual (the victim) is entitled to receive, in damages, the amount of money which will restore the victim to the position he or she was in before the accident. Tort-based recovery, for present purposes, has two important characteristics: generally speaking only the victim can seek recovery, and the victim's recovery, to a great extent, is based on the victim's individual circumstances.

1.12 It will be obvious that compensation based on no fault principles is, fundamentally, the opposite of compensation based on tort. It differs in one principal characteristic in that any injured party, not just the victim, can seek recovery. It does not follow, in theory, that recovery cannot be "tailor-made" for the injured individual (although that is often the practical result for reasons which will be reviewed in this Report).

1.13 Much of the compensation paid to those injured in automobile accidents is paid through automobile insurance, i.e., this insurance is a principal funding mechanism for such compensation. In Ontario, the contract of automobile insurance is in a standard form, approved by the Superintendent of Insurance. It provides compensation on both a tort, or third party liability basis (payments from insurer to victim on behalf of tortfeasor), and on a no fault, or first party basis (payments from insurer to insured, whether or not insured is at fault). Both types of coverage are mandatory. In addition, there are certain coverages (a mandatory one, relating to uninsured motorists and an optional one, relating to underinsured motorists) which are paid on a first party basis if an insured is injured through the fault of another who is unable to pay the damages in whole or in part because of lack of, or limited, insurance.

1.14 As a result, the compensation system in Ontario could be described as a hybrid because it offers both tort and no fault recoveries.

1.15 It should be clear from this review that reduction of the cost of benefits, or compensation, is not inherent in, nor does it automatically flow from, compensation based on no fault principles. It is unfortunate that many in Ontario assume that no fault insurance by definition means less costly insurance. What is not understood is that no fault insurance is a method of paying benefits, not a method of funding benefits.

1.16 This point can be underscored by reference to the implementation of no fault insurance in the United States, a subject much canvassed at the Hearing.

1.17 A concerted effort to move from tort to no fault compensation was launched in the United States in 1965 with the publication of Basic Protection for the Traffic

Victim, by Keeton and O'Connell. It combined criticism of various features of tort compensation with strong advocacy in favour of the features of no fault compensation. The authors proposed a model statute which would limit the right to sue in return for guaranteed no fault benefits for income loss and medical expenses.

1.18 Mr. Perry (Associate General Counsel, State Farm Mutual Automobile Insurance Company) had this to say of the approach taken by Keeton and O'Connell (Transcript, at 5026):

> They did not, in their presentation, focus on reducing costs. Their message was essentially that the insurance premium can be utilized to greater value for insurance policy holders.
>
> In their proposal ... was that the system be reconstituted from the liability insurance component and putting these dollars back into a system of first party benefits. Their system was a modest system.

1.19 By 1985, 16 states had introduced some form of no fault compensation, combined with some type of restriction on lawsuits against tortfeasors for recovery of damages. Eight states had introduced some form of no fault compensation but had not restricted the right to sue (these are often referred to as "add on" states), and the remaining states maintained compensation based on tort.

- Exhibit 14.6, at 1-2
- Chapter 2

1.20 It should be noted that, using American terminology, Ontario would be considered an "add on" no fault jurisdiction.

- Exhibit 14.6, at 1
- Ernst & Whinney (Bryan), Transcript, at 2794-95

1.21 Of the American witnesses, many of whom were adverse in interest on many points, most agreed that no fault compensation was introduced in U.S. jurisdictions primarily because it provided compensation to those who otherwise received none and because it provided more speedy payment of medical expenses. In particular, given that universal medical coverage through a program such as OHIP is not available in the United States except for the elderly or the poor, injured persons would receive some assured level of medical benefits. As stated by Mr. Bryan of Ernst & Whinney, a witness appearing on behalf of the Industry Coalition, implementation of no fault in the United States "... has given quite a bit of emphasis to the benefit side of the equation instead of to the cost side of the equation."

- Bryan, Transcript, at 2976-77
- Priest, Transcript, at 6185-86, 6240-42

- Baker, Transcript, at 6606

1.22 As noted above, 16 states decided to fund the introduction of compensation based on no fault principles by way of restricting recovery in tort below either a monetary or a verbal (types of injury) threshold. The savings in tort were to be applied to fund the on-going no fault benefits over time. Thus in those states, certain expenses were to be removed or reduced in order to fund a new and different type of benefit schedule.

3. The Choice Model

1.23 Choice has always been a feature of contracts of automobile insurance. Although Ontario, like most jurisdictions, has mandatory coverages and mandatory minimum limits, nevertheless consumers have always been able to choose among non-mandatory types of coverage and to choose deductible levels. In recent years, some other jurisdictions (particularly Kentucky and New Jersey) have allowed consumers choices which affect their rights to sue in tort. In particular, since January 1, 1989, an insured in New Jersey has had the right to choose between an unrestricted right to sue in tort, and no fault compensation combined with a limitation on the right to sue unless the injury meets a verbal threshold.

- Submission of Board Counsel, Appendix 2.A (Kentucky), at para. A.5 and Appendix 2.C (New Jersey), at paras. C.7, C.10

1.24 One of the proponents of this type of choice -- relating to the fundamental basis of recovery -- is Professor Jeffrey O'Connell, the early advocate of no fault compensation. Professor O'Connell and Robert H. Joost have written in a law journal article (Exhibit 14.12, at 62-63):

> No-fault auto insurance is a very controversial political issue that generates considerable public debate and lobbying by special interest groups. The result of this pressure in many states has been the enactment of hybrid insurance schemes that essentially graft no-fault benefits on top of an existing traditional liability system, without sufficiently reducing the scope of the traditional system.

The authors, throughout the article, make clear their concern that while benefits have increased through no fault, so have costs (at 76). Although the authors appear to prefer the implementation of compensation based exclusively on no fault principles (at 74) -- the analogy is workers' compensation -- they are of the view that it would be unpalatable, or unsaleable, to many, including the American trial lawyer lobby (Reiersen, Transcript, at 694). Their proposal is to allow insureds a choice between compensation based only on tort, or compensation based only on no fault.

C. THE OPTIONS IN THE REFERENCE

1.25 Three alternative models for the key contractual provisions between insurer and insured are before the Board in this Reference. These models represent not only benefit packages, but more accurately combined benefit and benefit funding packages. Two of the options -- Options 1 and 2 incorporating verbal thresholds -- are drawn directly from two American states. Option 3 -- choice -- is superficially similar to, but by no means the same as, the O'Connell and Joost proposal reviewed in paragraphs 1.23 and 1.24. Option 3 is not in operation, nor has it been proposed, in any jurisdiction to the best knowledge of all witnesses before the Board.

1.26 Option 1 (Reference, Schedule 1, a(i)) limits the right to sue for non-economic loss unless the bodily injury/impairment meets the following threshold: death, serious impairment of a bodily function, or permanent serious disfigurement. This is almost the same as the verbal threshold provided by statute in the State of Michigan.

1.27 Option 2 (Reference, Schedule 1, a(ii)) limits the right to sue for non-economic loss unless the bodily injury/impairment meets the following threshold: death, dismemberment; significant disfigurement; loss of a fetus; a fracture; permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than 90 days during the 180 days immediately following the occurrence of the injury or impairment. This is the same as the verbal threshold provided by statute in the State of New York.

1.28 Option 3 (Reference, Schedule 2) allows consumers to choose the form of compensation which they and their dependants would be entitled to receive subsequently in the event of bodily injury in an automobile accident. The choice is between:

- The no fault form (choice no fault), in which insureds would receive a defined level of benefits for economic losses regardless of whether they were at fault in the accident, but the insureds would not have the right to sue for non-economic losses or economic loss in excess of no fault benefits.

- The fault form (choice tort), in which insureds would retain the right to sue and recover for all losses from their own insurer, including economic losses up to the limits of the insurance policy, if they can prove the other driver was at fault.

1.29 The provenance of the choice option is not certain. The Board notes that, on December 14, 1989, Allan O'Donnell, as Counsel for the Insurance Bureau of Canada (IBC), submitted a document entitled "The IBC Choice Proposal" (Exhibit 19.9, revised as at January 13, 1989) to the Ministry of Financial Institutions (Transcript, at 5496). (Mr. O'Donnell appeared at the Hearing as Co-Counsel to the Industry Coalition.) Option 3 of the Reference is very similar to this proposal.

1.30 Each of Options 1 and 2, and choice no fault, incorporates no fault benefits which are enriched compared to those currently available under Schedule C of the Insurance Act, R.S.O. 1980, c.218, as amended, which are carried over to Section B of the standard contract of automobile insurance approved for use in Ontario (SPF 1).

1.31 It should be noted that the enriched no fault benefit levels have been taken from the Osborne Inquiry Report (Exhibit 13.6.1, at 570 ff.). The important backdrop to these benefit levels is that Mr. Justice Osborne did not recommend either a threshold approach to no fault or pure no fault, but favoured the tort system (combined with expanded no fault benefits), that is, "... preserving a compensation distinction between those who cause accidents and those who do not" (at 567).

D. THE SCOPE OF THE REFERENCE

1. Threshold Definitions

1.32 The Board was given two particular formulations of a verbal threshold. In preparing to report to the Lieutenant Governor in Council, the Board has not explicitly considered the broad question of why the Michigan and New York verbal thresholds, on which they are based, are worded as they are. The Board is not authorized to consider the issue of alternative verbal thresholds or alternative systems and to report thereon. The interpretation of the thresholds is an issue which, for some purposes relating to level of recovery and operational issues, is within the Reference. It is useful, therefore, to present two challenging, and perhaps opposing, views of these thresholds.

1.33 A paper prepared by Dr. Ronald Kaplan, a clinical psychologist and neuropsychologist (Exhibit 19.27) was available to the Board. He observes that many threshold schemes -- in the Board's view, including Michigan and New York -- are based on a biomechanical or lesion approach to injury, attempting to measure tissue damage rather than dysfunction and disability (at 3), but that "[t]he notion that medicine can assess tissue damage and relate tissue damage to dysfunction and disability is no longer accepted in the modern health care system" (at 11). Dr. William Franks, a specialist in the management of patients with acquired brain damage, put this concept in simple terms (Transcript, at 4801):

> I think one of the reasons is because these people look normal. If you have got a cast on your leg you are not expected to run around the block. If you have a broken brain and you look normal people expect you to go to work.

The Michigan threshold became law in 1973, the current

New York one in 1977. Neither threshold has been amended since that time and therefore cannot reflect any relevant advances in understanding injury and trauma.

1.34 The second view was expressed by Professor George Priest who argued that these verbal thresholds had proved difficult to interpret because of a disjuncture in that they are defined in medical terms, while their purpose is to effect cost savings. The result is that every case is a "battle of philosophies" because the purpose or intent of the provision is not clear on the face of the statute (Transcript, at 6575).

1.35 It is for the Government to decide if the wording of the threshold merits consideration.

2. Contractual Provisions

1.36 The Reference refers to Options 1, 2 and 3 as "systems". The principal information provided to the Board in the Reference pertains to the types of benefits and the level of benefits to flow from each option. In fact, there are many other matters of significance which must be included in the contract between insurer and insured which have a costing implication. In lieu of a draft form of contract for each option, the Board directed that every party or limited intervenor which intended to present a costing of any or all of the options was required to use the same set of assumptions (although costings on different assumptions also could be presented). Board Counsel, in consultation with those interested, prepared a set of assumptions (32 in all) to be used as the standard (Exhibit 5.3.2).

1.37 It should be noted that it has been assumed that the options apply only to bodily injury claims and that property damage will continue to be handled on the same basis as today.

3. Regulatory Infrastructure

1.38 The Reference is silent on the principal features of the regulatory infrastructure which will govern aspects of the relationship between insureds and insurers apart from the core coverages. On the one hand, the Board could assume that today's regulatory tenor will alter dramatically and that there will be a change to free market conditions for matters such as classification, rating, underwriting, consumer information and consumer complaint resolution. On the other hand, the Board notes that, generally, product reform in other jurisdictions has been twinned with either the maintenance of a substantial regulatory presence, or the implementation of augmented regulatory initiatives.

1.39 The Board, in this Report, does not select either as a working assumption but will attempt to identify what types of activity have served a purpose in other jurisdictions, and the relevance of that experience to Ontario. This approach may have a destabilizing effect on the costings of the options, only because different regulatory requirements can produce higher or lower costs, either directly or indirectly. The sensitivity of the costings to the variables must be appreciated and taken into account when the Government decides on the type of product reform to be introduced.

4. Distribution of Costs Arising from Automobile Accidents

1.40 Stepping back from the terms of the Reference and its focus on the cost of private passenger automobile insurance, there is a significant public policy issue pertaining to whether the costs of reparations for automobile accidents should be borne entirely by automobile users. The alternative, which is capable of infinite variations of degree, is to spread the cost to other public and private plans. These include OHIP;

federal and provincial disability plans; provincial income support plans; and, accident and sickness or disability insurance, whether purchased on a group or individual basis.

1.41 A related question is, assuming that compensation to individuals will not be fully available and funded within the automobile reparations system, whether there are individuals who will suffer because of lack of access to, or ineligibility for, public and private plans, or benefits. This question becomes particularly important if any or all rights to recovery of excess economic losses over and above no fault benefits are restricted, which is not a feature of any of the options before the Board.

1.42 Some guidance on these points can be found in the terms of the options. Although the Board will comment on some matters relating to these public policy questions as they are suggested by the specific questions on which the Board is to report, the Board has not studied the merits or feasibility of the possible policy approaches.

5. Accident Frequency and Severity

1.43 Understandably, much effort is being given to initiatives which could be implemented in the short term to give relief from current premium levels. A theme which ran throughout the Hearing was the great need to get to the root of the cost problem, and identify and implement effective measures to control automobile accidents.

1.44 The Board will consider, in this Report, whether any of the options might contribute to an increase in accident frequency or severity. Any consideration of the broad issues relating to accident frequency and severity, however, is beyond the scope of the Reference.

6. Alternatives to Threshold and Choice

1.45 The Board is required to consider three specific alternative forms of coverages which are set out in the Reference. It is clear from evidence at the Hearing, and from the public press, that there are other proposals for change being discussed in the public realm.

1.46 The insurance companies that appeared in the Hearing at the request of the Industry Coalition did not support the choice option as their first preference, but did support it as their second preference.

- Allstate, Transcript, at 2122-23, 2589; State Farm, Transcript, at 5519; Dominion, Transcript, at 4205, 4216, 4283-84; Royal, Transcript, at 4993; Zurich, Exhibit 21.8, at 3-4

1.47 The preferred option of these companies (although not of all companies that appeared before the Board) is pure, or only, no fault compensation. It was confirmed at the Hearing that the IBC (which represents most of the insurers carrying on automobile business in Ontario) adopted pure no fault as its preferred option by resolution of the board of directors passed on May 4, 1989 (Transcript, at 5496). The Consumers' Association of Canada (Ontario)(CAC) also supports a form of pure no fault compensation but one with increased benefit levels over those included in the Reference (Final Written Argument, at 23).

1.48 The Ontario Farm Mutuals Association (the Farm Mutuals) preferred Option 1 (the Michigan threshold) and rejected Option 3 - choice.

- Perry, Transcript, at 3839-40, 3862, 3864

1.49 During the course of the Hearing, FAIR released to the public a plan entitled "Enhanced Benefits Deductible Plan". The Board was of the view that this proposal, like a plan restricted to pure no fault compensation, clearly fell outside the terms of reference. The Board therefore ruled that neither plan would be considered by the Board for any purpose in its Report to the Lieutenant Governor in Council. The Board agreed to a request made by FAIR that it inquire whether the Minister of Financial Institutions wished to broaden the terms of the Reference to include the Enhanced Benefits Deductible Plan, and at the request of other interested parties also posed the same question with respect to a pure no fault plan. The Minister responded by confirming that the terms of reference would not be amended.

- Exhibits 36.2, 36.3

1.50 As a result, the Board, in this Report, confines itself to the options included in the Reference. The Board is of the view, however, that a caveat is in order. The choice option includes pure no fault coverages. Had the Board been considering pure no fault as the sole and exclusive compensation system for Ontario, the Board would have subjected it to a different type of examination and analysis than that which is required when it is coupled with choice tort. In particular, issues relating to the nature of mandatory and supplementary coverages, as well delivery of benefits, would have required rigorous testing. Pure no fault is very different from choice no fault and the Board makes no findings, conclusions or recommendations with respect to pure no fault.

E. PARTICIPATION OF THE PARTIES

1.51 The Board is grateful that Board Counsel and the parties were able to respond to the demands of this wide-ranging Hearing as they did, particularly with respect to the presentation of expert witnesses. They all came on short notice, many from outside the Province. Although it could be said that every party had a particular set of interests to serve, it is precisely that motivation which ensures testing of the evidence.

1.52 The Board will have considerable comment with respect to the detailed costing proposals prepared by Tillinghast (at the request of the Board) and The Wyatt Company (at the request of the Industry Coalition). These costings were difficult and complex, completed in what must be close to "record time". The Board notes the professionalism displayed by the actuaries representing these companies and their efforts.

1.53 A number of the parties represented what could be described as voluntary organizations, and several of these parties made significant contributions throughout the Hearing, both in presenting evidence and testing the evidence through cross-examination. The Board does not underestimate the strain it places on their limited resources to make this contribution to the development of public policy. These parties represented members of the public who share interests which are certain to be affected by whatever decision about product reform is taken. The Board in the past has requested that intervenor funding be available to the Board. The magnitude of public interest and concern about the issues before the Board, in the view of the Board, amply warrants the provision of intervenor funding.

F. ROLE OF THE BOARD

1.54 It is clear from the terms of the Reference that the Board is not authorized to draw any conclusions or make any recommendations with regard to the merits of the three options included in the Reference. Some evidence was outside the terms of reference but was of such significance that it will be recorded. The Board, however, views its role as one of identifying and analyzing the evidence relating to the specific questions posed to the Board, and making findings with respect to those questions. In performing that task, the Board can only be as specific as the Reference or the evidence will permit.

1.55 The Honourable Murray Elston, Minister of Financial Institutions, in a statement given on April 17, 1989, stated that the Government of Ontario has concluded that insurance product reform is necessary. The Board is aware, from this and other public statements, of the importance which the Minister attaches to receipt of this Report. The Board also is aware of the stress on the marketplace which is affecting both insurers and insureds in this interim period. For these reasons, the Board has moved as quickly as possible to prepare and release its Report.

1.56 This Hearing was lengthy, and it touched upon many issues of significance and complexity. The oral evidence, submissions and arguments, fill 29 volumes of transcripts (7414 pages). The Board heard 74 witnesses. A simple listing of the written exhibits is 19 pages in length. There are also written submissions and arguments. The most useful and objective summary of the evidence can be found in the written submission of Board Counsel.

2. THE HEARING

A. NOTICE OF HEARING

2.1 A Notice of Hearing, dated March 9, 1989, was published in 11 daily newspapers and 250 weekly newspapers, and a Notice was served on all participants in the Industry-Wide Hearing I-88-1, all insurers, and on persons who had contributed to the Osborne Inquiry (for a total of 724 persons). The Notice set dates for the pre-hearing conferences and the Hearing. The Notice set April 12, 1989 as the commencement of the Hearing.

2.2 Lists of the persons served and of the newspapers in which the Notice of Hearing was published can be found in Appendix B.

B. THE PRE-HEARING CONFERENCES

2.3 A pre-hearing conference was held on March 21, 1989. The Board dealt with matters of procedure and a preliminary list of issues, prepared by Board Staff, was distributed.

2.4 A second pre-hearing conference was held on April 7, 1989. The preliminary list of issues was discussed at this conference and issues were added or refined on the recommendations of the persons present. A procedural order, setting out the issues, settling procedural matters, and rescheduling the commencement of the Hearing to April 17, 1989, was issued on April 10, 1989 (Procedural Order - 1).

2.5 The published Notice of Hearing and Procedural Order-1 have been included in Appendix C.

C. BOARD CONSULTANTS

2.6 Section 7(2) of the Act gives the Board authority to engage persons to provide professional, technical and other assistance to the Board. Consultants were engaged by the Board in this Hearing. They were asked to address one or more of the matters set out in the Reference; to prepare a report and file it with the Board; and to attend at the Hearing as witnesses to speak to their respective reports. The consultants, although paid by the Board, are not "consultants for the Board" and are totally independent of the Board. They are given general instructions by Board Staff, but are not told what conclusion they should reach in their reports. Their evidence, like that of all other witnesses called by the parties, was subject to cross-examination by the parties and to questions put by the Board.

2.7 The Board engaged Tillinghast, a Towers Perrin Company (Tillinghast) to price the three options set out in the Reference. Tillinghast is an employee benefit and actuarial consulting firm. It has actuarial experience in the property and casualty insurance industry. The Tillinghast report, "Costing of Alternative Compensation Systems for the Victims of Automobile Accidents" dated April 3, 1989, was filed in the Hearing as Exhibit 5.1. On April 4, 1989 the Tillinghast report was made available to the parties in the Hearing and to all persons who requested a copy. The Board has distributed approximately 500 copies of the Tillinghast report. Messrs Oakden and Trudeau attended at the Hearing as witnesses.

2.8 The Board engaged Econanalysis & Associates (Econanalysis) to prepare a report on the adequacy of the proposed no-fault disability income benefits for victims of automobile insurance. The Econanalysis report, "Adequacy of No-Fault Disability Income Benefits for Victims of Automobile Accidents" dated May 17, 1989, was filed in the Hearing as Exhibit 31.1 and distributed to the parties. A panel of three witnesses, Professors

Evans and Krashinsky and Ms. Zukowski, appeared as witnesses.

2.9 The Board also engaged legal counsel to act as Board Counsel in this Hearing. Board Counsel was very active in calling witnesses, including witnesses from Kentucky, Michigan, New Jersey, New York, Pennsylvania and Quebec. The Board is very appreciative of the co-operation received from the witnesses from these jurisdictions who attended voluntarily and added their experiences to the Board's consideration of the matters before it. The Board appreciates also the participation of the two members of the judiciary, Mr. Justice Osborne and Judge Killeen, who agreed to requests from Board Counsel to attend the Hearing as witnesses. Board Counsel also retained two American law firms to report on the meaning of threshold in their respective states. Mr. Schnitter of the firm Saperston & Day, P.C., a member of the New York bar, prepared an opinion on the New York threshold (Exhibit 15.1). Mr. Gromek of the firm Plunkett & Cooney, a member of the Michigan bar, prepared an opinion on the Michigan threshold (Exhibit 18.1). Both Mr. Schnitter and Mr. Gromek attended at the Hearing as witnesses.

D. THE HEARING

2.10 The Hearing commenced on April 17, 1989 and adjourned on May 29, 1989. The Board sat for extended hours during the Hearing, a total of approximately 210 hearing hours. On May 11, 1989 the Board provided a simultaneous translation service for witnesses from the la Régie de l'assurance automobile du Quebec (the Régie). Argument was written, filed on Friday, June 2, 1989, with an oral supplement heard on the same day.

2.11 Parties have the right to call their own witnesses, as well as to cross-examine other witnesses. Many parties at the Hearing called a number of witnesses, including witnesses from out-of-province, which assisted the Board in its understanding of the concerns of the parties.

2.12 A daily transcript was kept of the Hearing. There are 29 volumes, a total of 7414 pages, including oral argument. Lists of the parties who appeared, the limited intervenors and the witnesses are included in Appendix D. An index to the transcripts (by witness) is also included in Appendix E.

E. THE REPORT

2.13 This Report includes the Board's findings and references to the evidence upon which the Board based its conclusions. All exhibits and transcripts are available for public inspection during office hours at the office of the Board located at 5 Park Home Avenue, 4th Floor, North York, Ontario, M2N 6L4 (telephone: (416) 222-2886).

3. LEVEL OF RECOVERY

A. INTRODUCTION

3.1 The systems of automobile insurance compensation referred to the Board comprise a threshold no fault system with two specified thresholds (the two threshold systems) and a choice system incorporating a no fault option (the choice no fault system). These are described in Schedules 1 and 2 of the Order in Council containing the Reference (see Appendix A) and in Chapter 1 of this Report. All three systems are "no fault systems" in the sense that they provide compensation to all injured persons, regardless of fault, on the basis of a defined schedule of benefits.

3.2 Under the two threshold systems referred to the Board, only persons whose injuries are sufficiently serious to meet the defined verbal thresholds may recover compensation for non-pecuniary loss (alternatively referred to as non-economic loss). Both threshold systems permit the recovery in tort of all pecuniary or economic losses in excess of the no fault benefits available under the insurance policy.

3.3 The choice no fault system involves compensation of all persons injured as a result of the operation of an automobile, regardless of fault, on the basis of the same schedule of no fault benefits as under the two threshold systems. This option, however, would eliminate the existing rights of persons who are not at fault to recover compensation in tort for both non-pecuniary loss and economic loss in excess of the benefits available under the automobile insurance policy.

3.4 There exists in Ontario today a system of "add on" no fault benefits, whereby certain income, medical, rehabilitation and other benefits are available to injured persons, irrespective of fault, under the accident benefits portion (Section B) of the automobile insurance policy. These benefits are additional to, and do not restrict in any way, the rights of injured persons to seek compensation in tort for losses in excess of those paid under the automobile insurance policy.

3.5 Ontario's system of add on no fault benefits was introduced in 1972. The benefit levels have not been increased since 1978. Under the three no fault systems referred to the Board, the current no fault benefits have been substantially enriched, and in fact duplicate in large measure the benefits recommended by Mr. Justice Coulter Osborne in his 1988 Report of Inquiry into Motor

Vehicle Accident Compensation in Ontario (Osborne Inquiry Report, Exhibit 13.6).

3.6 The referred systems are three of several options for "product reform" that have been advocated by insurers at various times in the past and that are being considered by the Government. An important focus of this Reference is the potential premium savings to be achieved under each of the three options referred to the Board. Hence, the Reference requests of the Board "an estimation of the average prices that would be charged for automobile insurance policies within the referred systems".

3.7 As the referred systems are intended also to implement the no fault benefit enhancements proposed by Mr. Justice Osborne, another matter referred to the Board by the Lieutenant Governor in Council was "an estimation of the level of recovery that would be achieved under the systems".

3.8 The evidence in the Hearing relating to level of recovery centered about two main issues, each of which will be discussed in turn:

a) the need for product reform and, in particular, the justification for funding the enhanced no fault benefits and premium reductions by limiting the level of recovery of certain injured persons; and

b) the adequacy of the proposed enhanced benefits, both in an absolute sense, and in the context of the three referred systems. The issue for many participants in the Hearing was the adequacy of the "trade off" -- that is, whether the enhanced no fault benefits are sufficient to justify relinquishing legal rights.

B. JUSTIFICATION FOR NO FAULT SYSTEMS

1. Background Considerations

(a) Affordability

3.9 Much of the support for the no fault systems referred to the Board appeared to be based upon the potential of these systems to reduce and control insurance costs and, therefore, insurance premiums. Indeed, with the exception of the Farm Mutuals, Kingsway, and Progressive, the support of insurers for the referred systems varied directly with the level of cost reductions that it was anticipated would be generated by each option.

3.10 As stated in Chapter 1, the evidence before the Board, in this and other hearings, indicated clearly the existence of a perception on the part of the public of an affordability crisis. The evidence of insurers, of individual insureds, of the Hamilton Automobile Club and of the Consumers' Association of Canada (Ontario) (CAC) was to the effect that insurance premiums are considered to be too high and must be reduced, and that future increases must be limited.

- State Farm (Fraser), Transcript, at 5022; Royal (Elms), Transcript, at 2639; Farm Mutuals (Bailey, Perry), Transcript, at 3849, 3906-07; Hamilton Automobile Club (Oakie), Transcript, at 6285-86; Hill, Submission, at 7-8; CAC (Hunter), Transcript, at 6783, 6849-50, 7012-13

3.11 On the other hand, it is of interest to note that numerous American witnesses, and particularly American insurance regulators, expressed the view that, from the perspective of their jurisdictions, Ontario premiums are reasonable for the coverage afforded.

- Reiersen, Transcript, at 679-80

3.12 Nevertheless, as stated by Board Counsel, Mr. Rogers, in his closing submission (Transcript, at 7184):

> The fact that the perception exists or is thought to exist is enough. That dominant fact throws a shadow over all of the evidence which the Board has heard, and I submit with respect that we are kidding ourselves if we do

> not assess the evidence against that omnipresent backdrop of affordability.

(b) Traditional Rationale for No Fault Systems

3.13 As a general proposition, the limitations imposed by no fault systems upon the tort rights of injured persons who are not at fault are justified on the ground that no fault systems permit the provision of basic economic benefits to all injured persons without the uncertainty and delay involved in a determination of fault. Hence the Order in Council referring the proposed systems to the Board states (Schedule 1, page 1):

> No fault benefits can be paid to the injured party relatively soon after the accident because no finding of fault is required and benefits are defined.

The social objective of speedy and certain compensation of economic losses for all injured persons is said to justify the denial of certain legal rights to injured persons who are not at fault.

3.14 Mr. Justice Osborne states in the Osborne Inquiry Report (at 451) that the rationale for the introduction of no fault benefits in Ontario in 1972 is somewhat unclear. The evidence before the Board is that the reason behind the introduction of threshold no fault schemes in the United States was a desire to provide motor vehicle accident victims with an assured level of compensation, especially medical benefits, in the absence in those jurisdictions of universal social programs, and in particular a universal medical insurance scheme.

- Creamer, Transcript, at 1262-64; Ernst & Whinney, Transcript, at 2773-74, 2923-25; Merin, Transcript, at 3384

3.15 In Ontario, on the other hand, accident victims currently have access not only to the no fault accident benefits available under Section B of the automobile insurance policy, but also to comprehensive medical coverage under the Ontario Hospital Insurance Plan (OHIP) and to a wide variety of federal and provincial disability and income support plans. American witnesses who appeared before the Board were universally impressed with the level of benefits currently available to motor vehicle accident victims in Ontario.

- Reiersen, Transcript, at 679-80; Creamer, Transcript, at 1294, 1353; Ernst & Whinney, Transcript, at 2811-12; Hunter, Transcript, at 6822-23; Baker, Transcript, at 6716; S. Miller, Transcript, at 5716-17

3.16 Even those American witnesses who supported threshold no fault systems in the context of their own jurisdictions, acknowledged differences in the social security environment between the United States and Ontario that should be considered in evaluating the need for the no fault systems referred to the Board.

- Reiersen, Transcript, at 680-82; Creamer, Transcript, at 1328-32; Hunter, Transcript, at 6841-42

(c) The Proposed Enhanced No Fault Benefits

3.17 The case for an increase in the current level of no fault benefits has been strongly made by Mr. Justice Osborne and others. As will be discussed at a later stage in this Chapter, parties differed as to the precise contents of an ideal no fault benefits package. Moreover, the support of some parties for the enhanced benefits incorporated in the referred systems was contingent upon the reparations system within which the benefits were delivered. Nevertheless, all parties before the Board agreed that the proposed no fault benefits, which are set out in Schedules 1 and 2 of the Order in Council, represent a necessary and desirable improvement over current benefit levels. While inflation since benefits were last adjusted in 1978 would alone justify many of the proposed enhancements, the Board notes that the evidence adduced at the Hearing strongly supported, in particular, the need for the proposed increases in rehabilitation, long term care and disability income benefits.

3.18 The proposed no fault systems would increase significantly the level of disability income benefits to the employed, from a maximum of $140.00 per week to a maximum of $450.00 per week, as well as provide for some groups, such as students and the "deemed employed", not previously covered. The need of injured persons for basic income maintenance is self evident. Evidence before the Board also emphasized the importance of an adequate income stream to the rehabilitation of victims.

- Crouse, Transcript, at 4524-25; Kaplan, Exhibit 19.27, at 7, 8; Corey, Transcript, at 3928-29, 3950-51; Rempel, Transcript, at 4766-67; Baptiste, Transcript, at 4817-18

3.19 Witnesses at the Hearing identified major gaps in the availability of rehabilitation services in Ontario. These include a wide range of necessary equipment, programs and services not covered by OHIP and other government programs, as well as a lack of available facilities and expertise, for the rehabilitative treatment of both catastrophic head and spinal cord injuries and less severe head and soft tissue injuries. In addition, there was evidence of a lack of available long term care facilities, with the result that many persons severely injured in automobile accidents are now forced to spend long periods of time in chronic care facilities.

- ARCH, Final Submission, at 38-41; Corey, Exhibit 23.3, at 2, Transcript, at 3922-23; Rempel, Transcript, at 4730-32, 4759-61; Franks, Transcript, at 4802-05; Rowe, Transcript, at 4809-11; Cherniak, Transcript, at 3790-92

3.20 The proposed medical and rehabilitation benefits would increase the current limit of $25,000 per person, for expenses incurred during a four year period from the date of the accident, to $500,000 per person for the longer of ten years or 20 years minus the claimant's age. An additional $500,000 would be available for long term care, with monthly benefits not to exceed the cost of group residence; members of a victim's family would be entitled to claim compensation.

3.21 While evidence established that these benefits are not optimal for the seriously injured, and are far less than would be available in tort to an insured who is not at fault (Cherniak, Transcript, at 3733-36), the Board accepts the assessment of the Advocacy Resource Centre for the Handicapped (ARCH) that the proposed benefits are an important and significant first step in addressing the problem of rehabilitation and long term care for injured persons (ARCH, Final Submission, at 38-

41). These benefits would be available to all injured victims regardless of fault -- a desirable social goal. Moreover, the evidence indicated that the increased rehabilitation benefits and the greater incentive of insurers to encourage rehabilitation as a result of their exposure for future wage loss would likely stimulate the availability of necessary services and expertise -- a desirable social and medical goal.

- Gromek, Transcript, at 1460-61; Corey, Transcript, at 3950-51; Rempel, Transcript, at 4746; Royal (Elms, Chick), Transcript, at 2698, 2706-07

2. Merits of Existing and No Fault Systems

3.22 The evidence established that the savings and enriched no fault benefits under the no fault systems referred to the Board are paid for, in large measure, by a reduction in the overall level of benefits currently available to injured persons who are not at fault. The evidence of the Tillinghast actuaries was to the effect that, of the $105 premium reduction initially costed under the first threshold option referred to the Board (Threshold Option 1), approximately two-thirds resulted from a reduction in benefits and one-third from "efficiency" savings, that is, a reduction in legal and adjustment costs. The comparable figures for choice no fault were approximately 75% benefits reduction and 25% efficiency savings.

- Oakden, Trudeau, Transcript, at 56-72

3.23 While the respective merits of the current system of compensation and no fault systems would appear to be beyond the terms of reference contained in the Order in Council, witnesses for FAIR (Fair Access to Insurance Reform) questioned the "moral justification" for funding the proposed premium savings and enhanced no fault benefits by reducing the level of recovery available under the current system to injured persons who are not at fault in a motor vehicle accident.

3.24 FAIR introduced a great deal of evidence both identifying those persons whose level of recovery would be reduced under the referred systems, and suggesting that the purported advantages of no fault systems have little basis in reality and therefore do not constitute justification for interference with legal rights. Proponents of no fault systems responded with evidence concerning the merits of the referred (and other) no fault options.

3.25 In light of the reductions in the level of recovery inherent in each of the referred systems, the Board considers some discussion of the merits useful, if only to point out considerations raised in evidence that are relevant to the policy choices that may be made. The evidence may be considered under three headings: equity considerations, efficiency considerations, and price considerations.

(a) Equity Considerations

3.26 The evidence under this heading dealt with restrictions on the level of recovery under the referred systems, as well as the relative equity of compensating victims on the basis of fault rather than need, and for economic as opposed to non-economic loss.

(1) Restrictions on Levels of Recovery

(i) Threshold Systems

3.27 Threshold no fault systems permit recovery of economic losses, but preclude recovery of non-pecuniary losses where the level of injury sustained fails to satisfy a defined threshold, which may be verbal or monetary. Non-pecuniary or non-economic loss involves three elements: pain and suffering, loss of enjoyment of life, and loss of expectation of life, which are compendiously referred to as "pain and suffering".

3.28 The two verbal threshold options referred to the Board are as follows:

a) Threshold Option 1 - death, serious impairment of a bodily function, or permanent serious disfigurement.

b) Threshold Option 2 - death; dismemberment; significant disfigurement; loss of a fetus; a fracture; permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than 90 days during the 180 days immediately following the occurence of the injury or impairment.

The abovementioned thresholds correspond to those curently in effect in Michigan (Threshold Option 1) and New York (Threshold Option 2).

3.29 Board Counsel obtained legal opinions from New York and Michigan attorneys, who also appeared before the Board and testified concerning the effect of the thresholds in those juridictions. In addition, FAIR called an attorney from Michigan and an attorney authorized to practice in New Jersey and New York. The witnesses called by Board Counsel were primarily defense attorneys; those called by FAIR were plaintiff's attorneys. The legal opinions, and evidence filed by FAIR, contained summaries of cases illustrating the effect of the thresholds.

- Schnitter, Exhibit 15.1, Transcript, at 821-908; Gromek, Exhibit 18.1, Transcript, 1409-1537; S. Miller, Transcript, at 5688-5785; Exhibit 19.18, 19.18(a); Baker, Transcript, at 6600-6717; Exhibit 19.25

3.30 The Michigan threshold is considered to be the more restrictive of the two verbal thresholds -- indeed, the most restrictive threshold in the United States. The criterion that has proved most difficult to apply is the phrase "serious impairment of body function". The evidence before the Board confirmed the following summary of the Michigan courts' interpretation of this phrase, taken from the Osborne Inquiry Report (at 475-78, footnotes ommitted):

> ... the definition and application of the threshold itself has been subject to varying judicial interpretation. In the cases immediately following the enactment of Michigan threshold no fault, the Michigan courts held that the issue of whether a plaintiff's injuries met the threshold was a question of fact for the jury. Only when the court found that reasonable minds could not differ on the application of the threshold did the issue become one of law for the court.
>
> Then, in 1982, in Cassidy v. McGovern, the Michigan Supreme Court rejected its previous decisions and ruled that as a general proposition, the issue as to whether an injury

is a serious impairment of body function is a question of statutory construction to be decided as a matter of law by the trial judge, not the jury. Only when there was a material factual dispute as to the nature or extent of the plaintiff's injuries was the matter to be submitted to the jury. In Cassidy, the Court stated that the phrase 'serious impairment of body function' was not susceptible to a simple definition; it did not attempt to define the phrase in its judgment. It gave the following important guidelines concerning the threshold:

(i) impairment of body function refers to impairment of an 'important body function' [emphasis added];
(ii) while the threshold does not require permanent injury, permanency is relevant;
(iii) the Legislature intended an objective standard that looks to whether the injury affects a person's general ability to lead a normal life; and
(iv) the Legislature intended that the injury be objectively manifested.

Three main reasons were given by the Court for its holding in Cassidy. The phrase 'serious impairment of body function' was not commonly used and, accordingly, the Court was of the view that juries would not have a clear sense of its intended meaning; further, in the Court's view, the legislative intent was to reduce litigation in automobile accident cases and this would not be achieved if a trial was required in most cases; and, finally, uniformity as to what constitutes a serious impairment in the Court's judgment could be better achieved by trial judges than by juries.

The Cassidy decision undoubtedly had the effect of making it more difficult for plaintiffs to meet the threshold. At the same time, by removing the threshold issue from the jury and allowing it to be determined by a trial judge on summary application, the Michigan Supreme Court likely removed an element of uncertainty from the system.

> In January 1986, in DiFranco v. Pickard, the Michigan Supreme Court reversed its holding in Cassidy. The decision in DiFranco returned the question of whether the plaintiff's injuries met the threshold to the jury, as long as it was one on which reasonable minds could differ. The Court in DiFranco also rejected the Cassidy guidelines of 'important body function' and 'objectively manifested injury', as well as the 'general ability to lead a normal life' test. The Court's opinion stresses that the Legislature did not intend to limit recovery of non-economic damages to the catastrophically injured. The threshold 'is a significant, but not extraordinarily high, obstacle to recovering such damages'.
>
> ....
>
> The Court held that the 'serious impairment of body function' threshold contains two inquiries:
>
> (a) What body function, if any, was impaired because of injuries sustained in a motor vehicle accident;
>
> (b) Was the impairment of body function serious. The focus of the inquiry is not on the injuries themselves, but on how the injuries affected a particular body function. Relevant factors are the extent of the impairment, the particular body functions impaired, the length of time the impairment lasted and the treatment required to correct the impairment. An impairment need not be permanent to be serious.

3.31 The DiFranco decision is widely perceived, and indeed appears, to represent a weakening of the threshold, as interpreted by Cassidy. However, witnesses testified that it is too early to gauge the effect of DiFranco. Apart from a list of claims summaries filed by State

Farm (Exhibit 4.20.6), in which settlements are stated to have been affected by DiFranco, no witness had specific evidence of the effect of the decision. Witnesses testified, however, that there are pressures in Michigan to enact legislation that would codify the Cassidy position.

- Creamer, Transcript, at 1319, 1321, 1339-40; Gromek, Transcript, at 1437, 1477; R. Miller, Transcript, at 1573; Groot, Transcript, at 2272-73; S. Miller, Transcript, at 5702-03, 5704-05, 5751-53; Hunter, Transcript, at 6965-66
- Creamer, Transcript, at 1367, 1374; Perry, Transcript, at 5031-32; S. Miller, Transcript, at 5704-07; Baker, Transcript, at 6659

3.32 The evidence before the Board indicated that the Michigan threshold precludes recovery not only for minor or transient injuries, but also for serious injuries involving hospitalization, operations, chronic pain, several months absence from work, and restrictions on an individual's previous employment, household and recreational activities. Witnesses confirmed that soft tissue injuries, psychological injuries and other injuries that are not objectively manifested tend to cause difficulties.

- Gromek, Transcript, at 1422
- Case summaries cited in Exhibits 6.7, 18.1, 19.18

3.33 The New York threshold is more detailed and specific. It is generally considered to be more certain, and less preclusive of claims, than the Michigan threshold, in part because of the categories that permit recovery for "a fracture", and "a medically determined injury or impairment of a non-permanent nature which prevents a person from performing substantially all of the material acts which constitute such person's usual and customary daily activites for not less than 90 days during the 180 days immediately following the occurence of the injury or impairment". The latter category would seem to permit recovery in cases that would not fall within the category "significant limitation of use of a body function or system", which is similar to the Michigan category, "serious impairment of body function". Dr. Corey, of the Behavioral Health Clinic, referring to data indicating that 80% of persons with soft tissue injuries recover substantially within six weeks of the injury, stated that very serious injuries could fail to meet the 90 day test (Transcript, at 4006).

3.34 Rehabilitation witnesses gave evidence to the effect that threshold systems requiring proof of permanency, objective manifestation and completeness of injury affect disproportionately and severely certain classes of injured persons. The Final Submission of ARCH states as follows (at 33-34):

> Below [the small group of catastrophically injured victims] is a considerably larger class of persons with injuries which are of considerable duration and severity, but vary as to outcome and as to consequences for a person's life. These include soft tissue injuries, minor to moderate head injuries, nerve damage, emotional trauma, and other injuries.
>
> ....
>
> [M]oderately injured persons often have difficulty in establishing the extent and duration of their disabilities, and tend to be adversely affected by reform proposals which tie compensation to objective diagnostic tests or to completeness or permanency of disability.

In written evidence, Dr. Kaplan, a FAIR witness, decried threshold schemes based on a "biomechanical or lesion approach" to injury, which attempt to measure "tissue damage rather than dysfunction and disability" (Exhibit 19.27, at 3).

3.35 Dr. Corey testified that the majority of long term disabilities are produced by soft tissue injuries, emotional trauma and mild to moderate head injuries -- injuries not easily susceptible to objective verification. Mr. Rempel, of the Ontario Head Injuries Association, and Dr. Franks, Director of Neurological Rehabilitation, Westpark Hospital, testified that mild to moderate head injuries produce cognitive, judgmental and personality dysfunctions that are not apparent from neurological examination. Rehabilitation witnesses testified that, while recovery for non-economic losses in respect of the abovementioned types of injury may be precluded under threshold systems, the injury or dysfunction can be proved in court and compensation obtained. These witnesses accordingly opposed threshold systems and favoured Mr. Justice Osborne's recommendations for reform of the current tort system with enhanced no fault benefits.

- Rempel, Transcript, at 4743-44; Rowe, Transcript, at 4812; Baptiste, Transcript, at 4813

3.36 A useful perspective on the verbal thresholds referred to the Board and their effect on persons suffering certain types of injury is provided by the IBC "smart no fault" threshold, which was raised in evidence on a number of occasions during the course of the Hearing. This threshold, which was supported by the IBC before the Osborne Inquiry, is similar to, but more preclusive than, the Michigan threshold. The IBC proposal strengthens the Michigan category, "serious impairment of body function" by adding the word "permanent", and defines "permanent serious impairment of a body function" to mean "an objectively manifested impairment of an important body function which permanently affects the general ability to lead a normal life". Mr. Justice

Osborne was critical of this threshold and dismissed it as unduly restrictive, and "designed to keep claimants out of the system for cost reasons, not to let the seriously injured in" (Osborne Inquiry Report, at 552-57). *In light of the evidence before the Board* concerning the effect of thresholds that require proof of permanency and objective manifestation, very serious analysis of such thresholds is required, as their only merit would appear to be the possibility of premium reductions.

3.37 While the threshold systems referred to the Board preclude recovery of non-economic loss below the threshold, they do permit recovery of all economic loss in excess of the no fault benefits available under the insurance policy. Notwithstanding the right to sue for excess economic loss, the Board accepts the evidence of FAIR that denial of recovery for non-pecuniary loss below the threshold will influence incentives to sue and will result in some claims for economic loss not being pursued. The evidence before the Board (including that of the actuaries) indicates that, in cases falling below the threshold, non-economic loss constitutes the major component of a personal injury award. Where recovery of damages for pain and suffering is precluded or doubtful, it will often be uneconomic under the cost rules governing litigation in this Province to pursue an independent claim for excess economic loss, or indeed for recovery of first party benefits in the case of insurer recalcitrance.

- Cherniak, Transcript, at 3725-26

(ii) Choice No Fault System

3.38 The choice no fault system would provide the same level of no fault benefits as the two threshold systems, but would deny recovery of all non-pecuniary losses, as well as economic losses sustained in excess of the no fault benefits available under the policy of insurance. This option obviously represents a very significant departure from the existing system of compensation; however, insureds may opt instead for the choice fault form, whereby an injured party may recover, from his or her own insurer, compensation for all losses, whether economic or non-economic, provided the other driver is at fault.

3.39 For those who are not at fault, the level of recovery under the choice no fault option would be much lower than under the current system or under any threshold system that leaves intact the right to recover all economic losses in excess of no fault benefits as well as the right to recover for non-pecuniary losses where the injury meets the threshold. For those who are at fault, the level of recovery would exceed that available under the current system and would be equivalent to that available under the two threshold systems.

3.40 The effect of choice no fault would be to extend the denial of recovery for non-pecuniary loss to a further class of persons -- those whose injuries would be sufficiently serious to meet a defined threshold. One point should be noted. As injuries become more serious, the non-economic component of a personal injury award becomes proportionately smaller. In a series of decisions commonly referred to as the "trilogy", the Supreme Court of Canada decided that non-pecuniary damages should be decided with reference to a "rough upper limit" of $100,000 in 1978 dollars for the most seriously injured. Accordingly, the maximum amount currently available for pain and suffering is approximately $208,000. This position differs markedly from the situation in the United States where dramatically higher awards are available.

3.41 A concomitant of the decision of the Supreme Court of Canada to limit non-pecuniary damages was the proposition that economic losses should be fully compensated. It is in the denial of recovery of excess economic losses - in particular loss of income and the cost of care - that the impact of a choice no fault (or a pure no fault) system is most severe.

3.42 The evidence indicated that those most severely affected by denial of damages for excess economic loss include the following victims of a motor vehicle accident caused by the fault of another:

1. The catastrophically injured. The $500,000 limitation for each of rehabilitation and long term care benefits has been discussed. Evidence indicated that, for those with severe head injuries and spinal cord injuries resulting in paraplegia and quadriplegia, far greater amounts are necessary if such persons are to be adequately cared for and realize their full potential. Under the tort system, a person who is not at fault may be awarded a very substantial amount (often in the millions of dollars), usually on a lump sum basis, to cover medical and rehabilitation expenses and the cost of future care, including attendant home care.

- Cherniak, Transcript, at 3698, 3705-09; Rowe, Transcript, at 4809-11; Rempel, Transcript, at 4776-77, 4780-81; ARCH, Final Submission, at 35-38

2. Dependants of a deceased victim. Upon the death of the head of a household with a spouse and two children, choice no fault would pay survivors' death benefits of $45,000.00. In tort, dependants may recover damages for loss of a deceased's future earnings, as well as non-pecuniary damages for loss of "guidance, care and companionship" under the Family Law Act, 1986. On behalf of FAIR, Laventhol & Horwath calculated the award for a spouse and two children of a deceased 45 year old earning $40,000 a year to be $573,400.

- Exhibit 19.13(a), Tab H, "George"; Laventhol & Horwath (Siegel), Transcript, at 5217-22; Cherniak, Transcript, at 3734-35

3. Persons with above average incomes. Any person earning more than $563 a week (80% of which is the maximum no fault benefit).

4. Young persons. Disability income benefits are capped at twice the insured's weekly earnings at the time of the accident. Inflation will erode the value of these payments after approximately 15 years, assuming an inflation rate of 5 percent. Tort awards, on the other hand, include amounts to compensate for the effect of inflation and also reflect future productivity gains.

- Exhibit 19.7, at 2

5. Persons with above average earning capacity. Unlike tort awards, which reflect the loss of an individual's earning capacity, the proposed no fault benefits base disability income payments on current, rather than anticipated future, earnings. Under the referred systems many students and newly employed persons would be compensated at a level that does not reflect their future earning capacity.

6. Persons temporarily unemployed or underemployed, such as persons who have temporarily limited or left employment to care for children, whose current earnings do not reflect their future earning capacity.

- Laventhol & Horwath (Siegel), Transcript, at 5197-5201; Exhibit 19.13(a), Tab B, "Carolyn"; Tillinghast (Oakden), Transcript, at 552-66; Evans, Transcript, at 5580

(2) Fault vs. Need; Economic vs. Non-Economic Loss

3.43 The superior levels of compensation available under the tort system are available only in cases where the injury is caused by the fault of another. Seriously injured persons who are at fault in an accident receive only minimal compensation under existing no fault benefits. Even the not at fault driver is not always guaranteed full recovery. Recovery may be limited where the policy limits of the tortfeasor, or under the victim's own uninsured or underinsured coverage, are insufficient to cover the losses sustained. Accordingly, much evidence was heard concerning the desirability of compensating all motor vehicle accident victims for economic loss on the basis of predetermined benefit levels, rather than only innnocent victims for individualized economic and non-economic loss.

3.44 Proponents of the various no fault options relied upon the proposition that most motor vehicle accidents are the result of momentary inattention or slight errors in judgment. The CAC took the position that tort as a system of compensation grossly undercompensates injured persons because (1) it relies on an unrealistic notion of the cause of accidents, thereby denying compensation to persons who, while technically at fault, are guilty of no more than inattention or an error in judgment; and (2) the degree of compensation to innocent victims depends upon such factors as the availability of adequate limits and the skill of the victim's lawyer.

- CAC, Final Argument, at 1-4

3.45 While the CAC did not dispute that non-pecuniary losses are real losses, it concluded that the better approach is to compensate economic loss on the basis of need, a position also adopted by the Industry Coalition. Mr. Hunter, the CAC witness, was emphatically of the view that compensation of economic loss was more important than compensation of non-pecuniary loss.

- Industry Coalition, Argument, at 23
- Hunter, Transcript, at 6781, 6890-91

3.46 ARCH agreed that the current tort system compensates at fault victims inadequately, and urged implementation of Mr. Justice Osborne's enhanced no fault benefits. With respect to compensation of innocent victims, ARCH drew no conclusions. It noted, however, that while compensation levels under tort are high, there are no statistics to indicate how many people in fact are compensated at that level. In its Final Submission (at 28-29), ARCH stated that, in the short to medium term, the following principle, enunciated by Mr. Justice Osborne in the Osborne Inquiry Report (at 45), should be adopted:

> A motor vehicle accident compensation system should deal humanely with all those who are injured and provide reasonably generous rehabilitation and long term care benefits on a no fault

> basis, while at the same time preserving a compensation distinction between those who cause accidents and those who do not.

3.47 FAIR pointed out that a large proportion of accidents are the result of advertent conduct such as drunkenness and speeding. It took the position that those who cause accidents should bear the cost of the harm they inflict, both from an economic point of view (see Chapter 5) and from the perspective of fairness. FAIR questioned the equity of compensating the "guilty" at the same level as, and in some cases more than, the "innocent".

3.48 The evidence of FAIR was to the effect that non-pecuniary losses are "real" losses. FAIR questioned the justification for denying compensation to a particular subset of injured persons. Professor George Priest, John M. Olin Professor of Law and Economics, Yale University, testified on behalf of FAIR as follows (Transcript, at 6278, 6279-80):

> No-fault cuts off pain and suffering awards for a certain set of the population. Now, the question is: What justification do we have for doing that? I don't think we have a justification per se for cutting off pain and suffering awards; that is, I don't think we can simply say these are not losses; therefore, we are not going to compensate them. That's not enough.
>
> Now, what then are the justifications for cutting off pain and suffering awards? Well,

> one argument might be juries are simply too generous and award too much money for these soft tissue, small soft tissue damages, but it is an odd argument to say we should cut off all recovery in those cases rather than to try and better inform jurors or try and better control the jury process.
>
> ....
>
> ... it seems to me the only other principal justification for a threshold system is the argument I alluded to earlier about administrative costs, that though these are real losses, the administrative difficulty of dealing with these losses is so great that we simply have to say we can't deal with it, in the way that some people say they won't pick up a penny on the sidewalk because it's too much trouble to bend over.
>
> Maybe that's what the proponents of no-fault are saying, but I think it's a hard -- I think it's a hard argument to make, but without an argument of that nature or without the argument about the jury it seems to me the argument becomes really quite cynical and cutthroat, and that is, we can lower insurance premiums by simply not awarding damages for these amounts.
>
> It is cynical because we could do the same thing by simply not awarding damages for property damage or not awarding damages for broken legs. Pick out an injury. If you break your leg, tough luck, you don't get recovery, everybody else gets recovery. If we cull out all the broken legs, we can lower insurance premiums.

3.49 Professor Priest also pointed out that the denial of non-pecuniary losses affects more severely certain groups within society -- that is, those who do not earn income, such as the elderly, the young, and homemakers, for whom compensation for pain and suffering constitutes the major portion of a personal injury award. In the words of Professor Priest (Transcript, at 6458-59):

> I think this point about moral controversy is taking -- is gaining great weight in the United States, in fact the leading arguments in the United States regarding pain and suffering damages, especially in the context of thresholds, have made the moral point that often these thresholds operate in a discriminatory manner toward the handicapped, toward women, toward other groups of the society that do not have -- whose roles in the society have traditionally been changing, been non-economic or non-pecuniary roles outside the marketplace.

3.50 It is significant that in Quebec, the government-administered and delivered no fault system of compensation for bodily injury (which precludes access to the courts) provides lump sum compensation for non-economic loss to persons who sustain permanent physical or psychological injuries or disfigurement. Employees of the Quebec Régie who appeared before the Board testified to public dissatisfaction with the current level of these awards, which resulted in proposed amendments that would increase the benefits from their current maximum of some $42,000 to $125,000 by January 1, 1992.

- Breton, Transcript, at 3152

3.51 The Board accepts that non-pecuniary losses are real losses, and that denial of recovery for such losses discriminates against one subset of injured victims. The Board notes that, beyond evidence indicating that non-economic loss constitutes the largest portion of smaller personal injury claims, no evidence was introduced indicating that such claims are unworthy of compensation.

(b) "Efficiency" Considerations

3.52 The evidence under this heading dealt with the relative efficiency of tort and no fault systems as means of compensating injured persons. Mr. Hunter, the witness for the CAC, argued that, in addition to the equitable argument in favour of no fault systems discussed above, such systems may be justified on the basis of efficiency (Transcript, at 6812):

> ... I believe there would be prompter payment, and I believe there would be more efficient delivery of benefits. That is, for every dollar ... you would in toto, not individually but in toto get back more in benefits.

The CAC did not, however, lead any specific evidence relating to efficiency.

3.53 Evidence dealing with the relative efficiency of fault and no fault systems as methods of compensation was presented by the Industry Coalition. Evidence prepared by Mr. R. Miller, the actuary retained by the Coalition, estimated, on the basis of data extracted from the data base underlying the Osborne Bodily Injury Claims Survey, that 33.5% of every bodily injury pure premium dollar represents legal costs and loss adjustment expenses, with 66.5% being paid out to the claimant. On the assumption that party and party costs equal 50% of the total amounts paid by the insured in legal and related fees and other disbursements, Mr. Miller estimated total legal costs (including insurers' costs) at 25.2%, and loss adjustment expenses at 8.3%, and concluded that $400,000,000 is spent annually in Ontario on legal fees and other disbursements.

- Exhibit 21.2.1, at 3-5; R. Miller, Transcript, at 1616

3.54 The Industry Coalition argued that there would be a reduction in legal fees and investigative costs under the referred systems, although the reduction in legal fees under threshold systems would be modest (presumably because of litigation concerning the interpretation of the threshold and in cases that meet the threshold). Under choice no fault, only investigative costs necessary to establish surcharges for premium pricing would be necessary.

- Argument, at 24-25

3.55 The Industry Coalition did not attempt to estimate the percentage of bodily injury premium that would be paid out to claimants under the referred systems (R. Miller, Transcript, at 1884-86). While it seems reasonable to assume that legal fees would diminish, particularly under the choice no fault system, there are additional costs, discussed in Chapter 6 of this Report, that would accompany implementation of the referred systems. These costs, which relate in particular to the resolution of disputes regarding no fault benefits and other administrative and regulatory costs, have not been calculated. Accordingly, no firm conclusion can be drawn on the basis of Mr. Miller's evidence concerning efficiency savings.

3.56 The Industry Coalition presented further evidence, which attempted to measure the efficiency of the U.S. no fault systems. A report, prepared by Ernst & Whinney, was filed (Exhibit 21.3). The report enclosed a 1985 study by the United States Department of Transportation (the D.O.T. study) and a 1989 American study prepared by the All-Industry Research Advisory Council (the AIRAC study). In its report (at 2-3), Ernst & Whinney set out the conclusions of the D.O.T. study, which include the following:

> 1. Significantly more motor vehicle accident victims receive auto insurance compensation in no fault states than in other states.
>
> 2. In general, accident victims in no fault states have access to a greater amount of money from auto insurance than victims in traditional states.
>
> ....
>
> 3. Compensation payments under no fault insurance are made far more swiftly than under traditional auto insurance.
>
> 4. No fault insurance systems pay a greater percentage of premium income to injured claimants than do traditional liability systems.

3.57 Data taken from the AIRAC study was presented to indicate that, generally, during the first year following an injury, more no fault (PIP) claimants and PIP dollars are paid than bodily injury claimants and dollars (Exhibit 21.3, Exhibit 2, at 8). Further evidence of the superior efficiency of no fault systems was offered in the form of an Exhibit setting out the ratio of total dollars of benefits paid out to claimants to dollars of premiums paid in in selected no fault and fault jurisdictions, as derived from the 1985 D.O.T. study (Exhibit 21.3, Exhibit 3, at 9). The authors concluded (Exhibit 21.3, at 4), "the pay out/pay in ratio tends to be higher in those states that have high first party benefits and restrictions that remove a significant portion of the claims from the tort system".

3.58 FAIR established in cross-examination of the Ernst & Whinney witnesses that, in cases other than those involving fatal and permanent injuries, 70% of the amounts paid out in PIP benefits represent medical payments, which in Ontario would be largely compensated directly through OHIP. In addition, FAIR also raised questions concerning the formula whereby the pay out/pay in ratios were calculated.

- Mandel, Transcript, at 2938-40, 2943-56, 2962-67

3.59 FAIR also challenged the objectivity and methodology of the D.O.T. study, as well as its conclusions and those of other proponents of no fault, concerning the superiority of no fault systems as methods of compensation. Professor Priest stated that the D.O.T. study constitutes "strong advocacy in favour of no fault", and objected to its choice of statistics as misleading and displaying a "unanimity of bias" in favour of no fault.

- Priest, Transcript, at 6199-6201, 6262-66, 6374; Exhibit 19.4, Section 1A

3.60 Professor Priest rejected, as "highly exaggerated", claims by the D.O.T., echoed by Professor Jeffrey O'Connell, a leading proponent of no fault, that no fault systems compensate "more people (roughly twice as many) with greater benefits (79 percent more) in quicker payment (almost all no fault payments, as opposed to only half of tort awards, are made during the first year of injury)".

- Exhibit 19.4, at 10

3.61 Professor Priest stated that "virtually all studies that show large differences between fault and no-fault systems compare bodily injury litigation to no-fault administrative settlement, and so fail to describe the system as a whole" (Transcript, at 6273). He argued that for purposes of comparing delivery of compensation in no fault and fault jurisdictions, regard must be had not simply to automobile insurance sources, but rather to all sources of compensation in each jurisdiction (Exhibit 19.14, at 12; Transcript, at 6188-89). Professor Priest referred to statistics from a 1985 auto victim study conducted by the Institute for Civil Justice of the Rand Corporation (Vol. III). These statistics indicate that, when compensation from all sources is taken into account, the differences between fault and no fault jurisdictions with respect to numbers of people compensated and levels of compensation largely disappear (Exhibit 19.14, at 10-21, especially Tables 1 and 2; Transcript, at 6185-6211).

3.62 With respect to the timing of payments in fault and no fault jurisdictions, Professor Priest concluded, on the basis of his analysis of statistics from the 1985 D.O.T. study (Exhibit 21.3, Table 3, at 18) and findings of the Rand study (Vol. II) concerning payment timing and attorney involvement that, while claims are paid more rapidly in no fault than in fault jurisdictions, differences are relatively modest. Where differences exist, they relate primarily to the small number of claims in which suit is filed, and reflect the requirements of the lump sum method of assessing damages, which encourages claimants to wait until the full extent of their injuries is apparent.

- Exhibit 19.4, at 17-21; Priest, Transcript, at 6201-11

3.63 Professor Priest testified that the increasing availability in the United States of non-automobile sources of compensation, together with the findings of the Rand study, have contributed to an erosion of support for no fault systems among American advocates of no fault. With the undermining of the original compensatory rationale, proponents must face the "morally controversial" issue whether administrative efficiencies of no fault systems justify the limitations on the rights of innocent victims inherent in such schemes (Transcript, at 6240-43).

3.64 In the course of cross-examination by Mr. Brown, Counsel for State Farm, Professor Priest conceded that studies have indicated that no fault systems return a greater percentage of premium dollars to injured victims than third party tort liability systems. Mr. Brown suggested that reliance on non-automobile sources of compensation shifts the costs that should be borne by the auto reparations system to other programs (Transcript, at 6484-86).

3.65 FAIR argued that, in light of the availability of OHIP in Ontario, Professor Priest's conclusions about the impact of other sources of compensation on the need for no fault schemes are particularly relevant (Final Written Argument, at 59). In a similar vein, Board Counsel, Mr. Rogers, and Mr. Beatty, Counsel for ARCH, emphasized, during cross-examination of Professor Priest, the relatively high level of compensation available under public compensation schemes in Ontario as compared to the United States.

- Rogers, Transcript, at 6342-46; Beatty, Transcript, at 6414-16

3.66 The position of the Industry Coalition with respect to the evidence concerning the U.S. no fault experience is perplexing. Counsel for the Industry Coalition, Mr. O'Donnell, cross-examined Professor Priest at some length concerning differences in the American and Ontario social welfare, legal, and regulatory environments that tend to render the U.S. experience irrelevant in this Province -- a position that would apply equally to the evidence of the Industry Coalition's witnesses, Messrs Bryan and Smith of Ernst & Whinney.

- O'Donnell, Priest, Transcript, at 6364-ff

3.67 The Board accepts Professor Priest's evidence that the claims of many U.S. proponents of no fault with respect to efficiency of compensation are inflated. The evidence before the Board suggests that caution is advisable in attempting to analyze American studies that purport to measure the relative efficiencies of fault and no fault systems. Moreover, the U.S. experience must be considered in the light of the current add on no fault benefits and the availability in Ontario of OHIP and other social welfare programs. While no fault systems may involve efficiencies, the Board is reluctant to draw any conclusions concerning this matter on the basis of the evidence presented at the Hearing.

(c) Price Considerations

3.68 In the final analysis, the Industry Coalition based its submissions respecting the level of recovery, and its support for the choice option, on price (Argument, at 22):

> One can only compare levels of recovery to injured persons if one considers price at the same time. Anything is possible for a price. For example, it is certainly feasible to deliver the current Tort system, but only at a great cost. That is why rates are presently so high. Similarly, it is clear that a threshold system will return more absolute dollars in total to accident victims than **CHOICE** No-Fault or a pure No-Fault system, assuming that accident benefits are the same under both, but it will only do so at an increased price.

3.69 Reference was made earlier to the concern about affordability of insurance that prompted this Reference to the Board. Two matters emerge from the evidence in respect of levels of recovery that bear discussion.

3.70 First, persons appearing before the Board differed with respect to the propriety of effecting premium reductions by means of a reduction in overall benefit levels. ARCH and FAIR rejected this approach as inequitable.

- Priest, Transcript, at 6349-50
- ARCH, Final Submission, at 45

3.71 The Hamilton Automobile Club, on the other hand, took the position that consumers are prepared to accept the types of restrictions on rights of recovery inherent in threshold systems in return for premium reductions. Indeed the Hamilton Automobile Club favoured Threshold Option 1, as strengthened to resemble the "smart no fault" threshold. Nevertheless, the Club's support for this threshold was contingent upon both a substantial initial premium decrease and assurance of future cost containment. If this could not be assured, the Club favoured retention of the existing tort system, with implementation of a broad package of tort reform. It should also be noted that, despite the greater premium savings inherent in the choice no fault option, the Hamilton Automobile Club did not favour that option, and emphatically rejected any pure no fault system.

- Hamilton Automobile Club, Exhibit 3.29; Oakie, Transcript, at 6286-87, 6294-97, 6322-25

3.72 Mr. Hunter for the CAC stated that premium reductions should be financed only by the efficiency savings in no fault systems; any savings achieved through benefit reductions should be returned to consumers in the form of enriched no fault benefits. Mr. Hunter acknowledged the "tension" between the goals of premium reduction and compensation, but stated that, for consumers, the goal of full economic compensation is paramount.

- Hunter, Transcript, at 6780-81, 6850

3.73 Secondly, there was strong evidence to the effect that no fault systems should not be promoted as premium reduction mechanisms. Although the purpose of no fault legislation in the United States was the provision of compensation, it was sometimes necessary, in order to obtain passage of such legislation, to implement no fault benefits in conjunction with a premium reduction. A number of American witnesses, including the Industry Coalition's witnesses, Ernst & Whinney, cautioned against the dangers of creating among consumers unrealistic expectations concerning price containment that cannot be met. In the words of Mr. Bryan of Ernst & Whinney:

> But the big risk is a perceived perception that no-fault was being introduced in order to reduce insurance premiums, and as a result of that, there is substantial pressure to reduce insurance premiums, and you go from an inadequate level to an even more inadequate level, and that's been -- certainly been the experience in several of the U.S. jurisdictions.
>
> [Q] I take it from that, that the one message you were leaving with us is that selling no-

> fault as a way of reducing premiums, can lead to a lot of problems. It's somewhat simplified, but --
>
> [A] It has led to problems in several U.S. jurisdictions. But again, there is a step even previous to that, and that's important for everyone involved in the process to decide to what do they want to give more emphasis? Do they want to give more emphasis to making sure that more people are compensated under the auto reparation system? Do they want to give more emphasis to reducing the premium which the average individual has to pay? And that choice needs to be pretty clear-cut or else all of the other pressures in the United States, at least, have led towards an environment of saying no-fault is good because it reduces premiums. And that is the -- can lead to trouble.

- Reierson, Transcript, at 646-47; Bryan, Smith, Transcript, at 2812-15, 2886-87; Priest, Transcript, at 6340-42; Hunter, Transcript, at 6913-15.

3. Conclusions

3.74 On the basis of the foregoing, the Board has reached the following conclusions:

1. There exists among Ontario consumers the perception that insurance premiums are too high.

2. There is a need to increase existing no fault benefits contained in Section B of the automobile insurance policy, SPF 1. The proposed enhanced no

fault benefits -- particularly the disability income benefits and rehabilitation, medical and long term care benefits -- represent a substantial improvement over current no fault benefit levels.

3. The enriched no fault benefits and any premium savings that would attend implementation of the three no fault systems referred to the Board are accomplished, in large measure, by a reduction in the benefit levels available under the current compensation system, which combines recovery in tort with "add on" no fault benefits under the insurance policy.

4. The threshold no fault options referred to the Board preclude recovery in tort for non-economic losses (pain and suffering).

   a) While Threshold Option 2 (the New York threshold) is less restrictive than Threshold Option 1 (the Michigan threshold), both are capable of denying recovery in respect of serious injuries, involving hospitilization, operations, several months absence from work, chronic pain and long term disability.

b) Non-pecuniary losses represent "real" losses. No evidence was presented to the Board that would establish that such losses are unworthy of compensation.

c) Threshold systems affect in a disproportionate manner moderately injured persons with soft tissue injuries, minor to moderate head injuries, emotional trauma, and other injuries that are not permanent or objectively verifiable. Thresholds that specifically require that injuries be objectively manifested or permanent require very serious analysis, as their only merit appears to be that they save costs.

d) Threshold systems may be challenged as operating in a discriminatory manner towards persons who do not earn income, such as homemakers, the young, the aged, and the unemployed, for whom compensation for pain and suffering represents the major, or sole, portion of a personal injury award.

e) The elimination of a right of action for non-economic loss below the threshold will discourage the assertion of claims for economic loss, as the latter will in many cases not be economically viable if asserted alone.

5. The choice no fault option referred to the Board eliminates entirely the right to sue for both economic and non-economic loss.

   a) Compared to levels of recovery available to those who are not at fault under the current system and under the referred threshold systems, choice no fault would represent much lower levels of recovery.

   b) While denial of non-economic loss would be extended under this option to all injured persons, the impact of the denial of economic loss is relatively more severe.

   c) The most severely affected include the catastrophically injured, dependants of a deceased, those with above average incomes, young persons, persons with above average earning capacity, and others whose income level at the time of injury does not reflect their earning capacity.

6. The superior levels of compensation that may be awarded under the tort system are available only where the injury is caused by the fault of another and where policy limits of the tortfeasor or insured are sufficient to cover the losses. No fault systems provide an assured level of benefits to all persons regardless of fault and policy limits.

7. The traditional U.S. rationale for no fault systems, which deny compensation to persons who are not at fault in order to compensate all persons regardless of fault, does not apply equally in Ontario, where injured persons currently have access to no fault benefits under Section B of the automobile insurance policy, to comprehensive medical coverage under OHIP, and to other universal social welfare programs.

8. The claims of many U.S. proponents of no fault with respect to the superior efficiency of such systems as mechanisms for compensating injured persons are inflated. While no fault systems may involve efficiencies, the Board makes no finding on the

matter on the basis of the evidence presented at the Hearing.

9. While the implementation of the enhanced no fault benefits is desirable, this could be accomplished within the framework of the existing system. On the other hand, without adjustment to the current system, the additional benefits could not be provided without premium increases. The primary rationale for the implementation of the enhanced benefits within the context of the referred systems is cost reduction. Whether the enhanced no fault benefits should be financed by means of a reduction in the level of recovery of injured persons who are not at fault is a matter of public policy to be decided by Government.

10. Premium reduction as a rationale for no fault systems is controversial and may create among consumers unrealistic expectations concerning the future price of insurance.

C. ADEQUACY OF ENHANCED NO FAULT BENEFITS

3.75 The enhanced no fault benefits included as part of the referred systems of insurance reflect, with very minor changes, the no fault benefits recommended by Mr. Justice Osborne. In the Osborne Inquiry Report, Mr. Justice Osborne outlines in detail the rationale behind the benefits proposed. The Board heard evidence concerning the adequacy of the enhanced no fault benefits, both in general terms, and with respect to the question whether they represent an adequate "trade-off" in terms of affordability and the legal rights that would be abrogated under the referred no fault systems.

1. General Level of Adequacy

(a) Income Disability Benefits

(1) Econanalysis

3.76 Econanalysis & Associates (Econanalysis) studied the adequacy of the enhanced no fault disability income benefits with a view to answering the following question:

> Will there be a reallocation of the burden of providing for recovery of injured persons from the auto insurers to social services and if so, what will be the indirect costs?

The study looked at adequacy from the perspective of income replacement (that is, whether the weekly no fault benefits are an adequate replacement for an individual or family's pre-accident, before-tax income) and whether they permit maintenance of the pre-accident standard of living. The study also considered income sufficiency, comparing household income to the poverty level as defined by Statistics Canada.

- Econanalysis, Exhibit 31.1, at 1-2

3.77 The methodology and conclusions of Econanalysis are summarized in some detail in the Submission of Board Counsel. The major findings of the study, which were not challenged, are as follows:

a) When compared to pre-accident before-tax weekly income, no fault disability income payments would not generally provide adequate support for all accident victims. While middle income individuals and families would generally be adequately compensated, those in the lowest and highest income tax brackets would be undercompensated. In the case of low income victims, inadequate compensation arises because of the lower tax rates applicable; in the case of high income earners, the reason for inadequacy is the ceiling on no fault income disability benefits. The shortfall is most severe for previously employed individuals with a long term disability and no private insurance, and for the deemed employed.

b) Similarly, the proposed no fault benefits are generally insufficient to maintain pre-accident standards of living for the majority of persons disabled in an accident.

c) Approximately 14.1% of unattached individuals and 6.5% of families are at risk of falling below the poverty level if forced, by reliance on no fault benefits, to incur a 20% reduction in their pre-accident gross earnings.

d) The percentage of the population at risk of requiring some level of social assistance as a result of a disabling accident is 20.3% for unattached individuals, 11.6% for a family of four, and 47.5% for a single-parent family.

e) Persons on welfare or social assistance programs, as well as persons who are unemployed and not deemed to be employed, would not receive any no fault disability income benefits, despite the fact that many persons in such positions would re-enter the labour market in the absence of an accident.

- Econanalysis, Exhibit 31.1, at 2-4, 34-35, 42; Transcript, at 5578-85, 5619-25
- Submission of Board Counsel, at 7/4-7/12

3.78 The authors of the study concluded as follows (Exhibit 31.1, at 5):

> Regardless of the extent of income replacement, no-fault disability benefits do provide some protection for those individuals whose current earnings reflect their productivity. However, no-fault benefits exclude those with no wage, like unemployed workers not deemed employed and social assistance recipients, and may provide inadequate protection to those whose current wage does not reflect their future productivity, such as those in training programmes. If disabled in an accident, these individuals could be forced to rely on social assistance for the duration of their disability, and perhaps permanently. In addition, the no-fault disability formula offers protection against inflation, but makes no provision for an injured worker's productivity improvements over time. These are serious short-comings that may argue in favour of giving an individual some recourse

to the tort system.

(2) Other Comments

3.79 Both ARCH and the CAC criticized the income disability benefits as too low, and suggested that they be established with reference to workers' compensation benefits, which currently are 90% of net average earnings, with an annual ceiling of $36,600.

- ARCH, Final Submission, at 41
- CAC, Final Argument, at 12

(b) Death Benefits

3.80 Death benefits were widely considered to be inadequate. It is significant that the Industry Coalition presented evidence to the effect that it would add only approximately $5 to the cost of each of the various options to increase the death benefits payable in the event of the death of a head of a household or a spouse to four times the previous year's gross annual income from employment, with a minimium of $50,000 and a maximum of $200,000, and to increase dependants' death benefits to $15,000.

- R. Miller, Transcript, at 1617-18; Exhibit 4.7.1, at Appendix E, at 6-8

(c) Medical and Rehabilitation Benefits

3.81 Although not optimal, ARCH considered the proposed benefits a positive first step, in the context of the existing tort system (see paragraph 3.21 above). The CAC proposed that an unlimited dollar amount be available for an unlimited time.

- CAC, Final Argument, at 12

(d) Long Term Care Benefits

3.82 Concern was expressed about both the maximum amount available ($500,000) and the limitation of long term care benefits to the monthly cost of group residence. The evidence indicated a lack of available group facilities for the catastrophically injured, and that the cost of attendant home care can approach $80,000 to $100,000 annually. No such limitation would appear to govern the provision of long term care in Michigan. The CAC proposed an unlimited dollar amount with no time limit.

- Cherniak, Transcript, at 3705-06, 3774-75
- Creamer, Transcript, at 1306-09, 1369-70
- CAC, Final Argument, at 12

(e) Replacement Services

3.83 Both ARCH and the CAC argued that the home care benefit of up to $50 per week for incurred expenses is totally inadequate. The CAC recommended a maximum of $200 per week for incurred expenses.

- CAC, Final Argument, at 12-13
- ARCH, Final Submission at 42

(f) Indexation

3.84 Under the Order in Council, the enhanced no fault benefits are indexed to the annual consumer price index, but are capped at twice the stipulated benefit. Objections were raised to the capping of benefits, particularly income disability benefits, because of the effect on young persons who are permanently disabled.

- ARCH, Final Submission, at 42
- CAC, Final Argument, at 12-13

2. Adequacy Under the Referred Systems

3.85 The no fault benefits recommended by Mr. Justice Osborne were never intended to operate as part of a threshold system that limits rights of recovery for non-economic loss, or in a no fault system that eliminates completely the right to sue in tort for damages. Appearing before the Board at the request of Board Counsel, Mr. Justice Osborne stated (Transcript, at 6954):

> ... it was a no-fault benefit package that some refer to being part of an add-on system where there is a third party offset, so that clearly the system that I preferred was one in which the tort rights would remain -- would continue to exist, and there would be increased no-fault benefits. If you look at the no-fault benefits on their own without those tort rights, I think some adjustments have to be made in the benefits.

3.86 The position of the CAC, which supported a system of pure no fault (an option not before the Board), was that there must be a quid pro quo for the relinquishment of legal rights. Moreover, the greater the restriction on legal rights, the greater the need to enrich the no fault benefits. In the words of Mr. Hunter:

> I would encourage the Board, by the way, to go as rich a benefits as possible. If in fact you can find a way to save the friction costs, that is great and that should be passed back in the premium savings. But if benefits are cut it seems to me that you ought to be considering enriching other benefits, economic loss type benefits to try to keep people roughly equal on their benefit levels.
>
> ....
>
> ... what I am saying here is we are considering changing legal rights. When we talk about no-fault that is a very serious decision, obviously, that's why I am sure you have been going on at such length here. And what I was just saying is that you want to make sure, I think, that the benefits are

> roughly equivalent to any reduced benefits.
>
> So if you reduce pain and suffering, for example, I think you ought to make sure that economic damages would be roughly equivalently raised so that people are compensated.
>
> I think pain and suffering is real, but so is economic loss and someone not getting compensated for pain and suffering, you can make a very sad story about that and it is very sad quite often. On the other hand, people not collecting their economic damages or pain and suffering are even more tragic.

- CAC, Final Argument, at 11-12; Hunter, Transcript, at 6780-81

3. Conclusions

3.87 The Board agrees that the adequacy of the enriched no fault benefits must be considered in the context of the reparations system within which they are to be delivered. A benefits package that constitutes the sole recourse of an injured victim must be viewed differently from one that eliminates only certain legal rights, or one that is available in conjuction with the right to recover excess economic loss and compensation for non-economic loss. The Board makes the following observations with respect to the question of adequacy of the proposed no fault benefits within the context of the existing and referred systems.

3.88 As an adjunct to the existing system of compensation, the proposed enhanced no fault benefits are adequate and represent a substantial and necessary improvement over the current level of benefits. With respect to the issue of cost, the Board heard suggestions that tort reform and a decrease in litigation resulting from the availability of substantially increased no fault benefits could fund the proposed enhancements. Moreover it was argued that the FAIR "Enhanced Benefits Deductible Plan" would permit a premium reduction. The Board makes no finding on these matters.

3.89 A policy decision on the part of Government to move to a threshold system of the sort referred to the Board would eliminate the right to recover non-economic losses in cases where an injury fails to meet the threshold. The Board considers the Michigan threshold system a significant limitation on the existing rights of injured persons. The impact of the New York threshold, while less severe, is also significant. Accordingly, it would be appropriate to consider enhancing the proposed package of benefits in return for this limitation.

3.90 A perusal of the no fault benefits available in Michigan indicates that benefits in respect of rehabilitation and long term care, in particular, are superior to those contained in the proposed Ontario package. The Michigan Insurance Code of 1956, Mich. Comp. Laws Ann. 500.3107, provides in part as follows:

> 500.3107. Personal protection insurance benefits are payable for the following:
>
> a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation ...

The benefits available are unlimited as to time or amount, so long as the statutory criteria of "reasonable" and "reasonably necessary" are met. The restriction in the Ontario long term care proposal, limiting the benefit to the monthly cost of group residence, is absent. The evidence of the Michigan witnesses was to the effect that the system is working reasonably well and has given rise to development of rehabilitation centres within the State. If unlimited benefits are to be adopted, the need for a reinsurance pool along the lines of the Michigan Catastrophic Claims Association has to be considered, as noted in Chapter 6.

- Creamer, Transcript, at 1305-08, 1369-71, 1401-02
- Gromek, Transcript, at 1453-54, 1460, 1530-34

3.91 In light of the fact that the two threshold systems before the Board (indeed all threshold systems in existence) permit the recovery in tort of excess economic loss, the Board does not consider further amendment of the proposed no fault benefits necessary to adjust for the fact that these benefits do not adequately compensate economic loss. As long as recovery for excess economic loss remains available in tort, a remedy is available to the not at fault individual for whom the level of no fault benefits is inadequate.

3.92 The choice no fault option abolishes the right to recover compensation in tort not only for all non-economic loss, but also for excess economic loss. With respect to economic loss, the evidence before the Board -- that of FAIR, the CAC, ARCH, Econanalysis -- is that the proposed enhanced benefits do not constitute adequate compensation for economic loss, nor appropriate value for the elimination of the right to sue.

3.93 If, as a matter of public policy, it is decided to adopt a no fault system -- such as the choice option -- that eliminates or limits significantly the right to recover excess economic loss, consideration should be given to examining and amending the proposed benefits with a view to correcting the deficiencies identified in this Hearing. Generally speaking, the Board considers the amendments proposed by the CAC, particularly those in respect of disability income benefits and indexation, to be roughly appropriate. Mr. Hunter of the CAC estimated that these changes would reduce the savings inherent in the choice no fault system by approximately 10% (Transcript, at 6828-29; Exhibit 30.2, at 6-7). The Board, however, would support more generous death benefits, at least equal to those put forward by the Industry Coalition (paragraph 3.80 above). Moreover, in light of the fact that choice (or pure) no fault would affect most significantly the catastrophically injured, unlimited medical, rehabilitation and long term care benefits equal to those available under the Michigan system should be included in the benefits provided.

D. ACCESSIBILITY OF NO FAULT BENEFITS

3.94 An adequate level of benefits will not assist injured persons if no fault benefits are not easily and quickly available when needed. Several witnesses testified that an increase in the level of benefits will be meaningless unless victims can in fact access such benefits.

- Corey, Transcript, at 3951; Baptiste, Transcript, at 4822

3.95 The Board agrees that, in considering the level of recovery under the referred systems, accessibility of benefits is as important as adequacy of benefits. The accessibility of no fault benefits is dealt with in Chapter 4, in conjunction with a consideration of ADR and other mechanisms designed to ensure insurer delivery of no fault benefits.

4. DELIVERY OF NO FAULT BENEFITS

A. INTRODUCTION

4.1 Among the matters referred to the Board is a request that the Board report concerning,

> The cost impact, if any, of the implementation of an alternative dispute resolution [mechanism], involving mediation and, if necessary, binding arbitration, for the settlement of no-fault compensation.

4.2 The Board heard a great deal of evidence concerning the need for an alternative dispute resolution (ADR) mechanism, both as a means of resolving disputes between insureds and insurers concerning entitlement to no fault benefits, and as one of a number of methods of improving insurer delivery of such benefits.

B. DELIVERY OF EXISTING NO FAULT BENEFITS

4.3 The issue of delivery of no fault benefits by insurers under the current system was addressed at some length by Mr. Justice Osborne in the Osborne Inquiry Report. He concluded (at 166):

> The insurance industry's performance in this

area is nothing short of abysmal.

4.4 This assessment was clearly confirmed by the evidence presented to the Board by medical practitioners and specialists involved in the rehabilitation and treatment of automobile accident victims; by individual insureds who appeared before the Board and who made written submissions to the Board; by the Hamilton Automobile Club; and by Mr. Cherniak, an experienced personal injury litigation counsel. The various Counsel for the Industry Coalition did not cross-examine these witnesses in respect of their evidence concerning insurer recalcitrance and delay.

- Corey, Transcript, at 3930-33, 3934, 3956; Rempel, Transcript, at 4733-34; Franks, Transcript, at 4801, 4804; Rowe, Transcript, at 4808-09, 4811; Baptiste, Transcript, at 4813-14, 4818-30; Hamilton Automobile Club (Newell), Transcript, at 6325-27; Cherniak, Transcript, at 3731-33; FAIR, Exhibits 19.17(a)to(c); Crouse, Transcript, at 4524-26, 4537-38; Watson, Exhibit 3.21; Corvese, Exhibit 3.27.

4.5 Witnesses from Allstate and Royal were questioned by Counsel for the Industry Coalition concerning Mr. Justice Osborne's conclusions with respect to the delivery of no fault benefits. Mr. Kelaher of Allstate, while denying any problem at Allstate, acknowledged the existence of difficulties within some portion of the industry, but attributed them to a failure to segregate claims staff dealing with first party claims from those dealing with third party claims. Mr. Elms of Royal stated that to overcome the "perceived problem or real problem even", Royal had no objection to the implementation of "standards" to ensure delivery.

- Kelaher, Transcript, at 2106-09
- Elms, Transcript, at 2613-14, 4985

4.6 During cross-examination by the parties and the Board, claims representatives of the two companies denied that there currently exist problems of any significance within Allstate or Royal with respect to the payment of no fault claims. Reference was made to the relatively small number of writs issued in respect of no fault benefits, but no statistics or other evidence were produced that would indicate the number of claims made, refused, and paid.

- Allstate (Rogers), Transcript, at 2475
- Royal (Chick), Transcript, at 2679; (Boyle), Transcript, at 4983-85

4.7 The thrust of much of the cross-examination conducted by insurers of witnesses who attested to problems of delivery was to elicit agreement that delivery would be improved if such mechanisms as ADR, payment guidelines, and penalties for late payment were in place. Insurers also suggested a number of factors that would lead to improved delivery under the referred systems. Among the arguments advanced were the following:

1. The substantial increase in the level of benefits would increase consumer awareness and would encourage insurers to deliver benefits.

2. Greater exposure to wage loss payments would encourage insurers to fund rehabilitation.

3. In the context of the choice no fault (or a pure no fault) environment, adversarial pressures would be absent and insureds would be dealing with their own insurers, rather than with the insurer of the at fault party. Insurers, competing on service, would have an incentive to ensure consumer satisfaction.

4.8 The first two arguments are plausible; indeed, in his evidence before the Board, Mr. Justice Osborne expressed the view that increasing the level of benefits would in itself assist in resolving the delivery problem (Transcript, at 6974). The third argument was made to Mr. Justice Osborne during the Osborne Inquiry. He responded in the Osborne Inquiry Report (at 561):

> This argument has a superficial appeal to it; there is, however, nothing in the history of the delivery of Section B benefits, of compensation under SEF 42 or SEF 44, or compensation under unidentified/uninsured motorist coverage (all provided at the first party level) to suggest that first party claims will be handled with more affection and less delay than is the case now. If there is any pervading shortcoming within the insurance industry at the claims level, it is in the delivery of first party benefits. It is unlikely that upon conversion to some kind of no fault compensation plan, claims-related dealings between insurer and insured will suddenly be dramatically improved.

4.9 Insurers indicated a willingness to make changes that would improve the delivery of first party benefits. These included the special training of claims personnel, and the establishment of internal procedures to review claims refusals. In addition, they indicated support for ADR and other mechanisms, such as sanctions for late payment, designed to ensure delivery.

- State Farm, Submission, at 5; Perry, Transcript, at 5056-57
- Royal (Elms, Boyle), Transcript, at 4978-79; Exhibit 21.5, at 5
- Allstate (Kelaher, Rogers), Transcript, at 2106-11

4.10 The Board notes the evidence of many witnesses that, to the extent no fault benefits are pursued under the present system, they are pursued by lawyers in conjunction with third party liability claims. If third party liability claims are restricted (under a threshold system) or precluded (under choice no fault), this avenue of redress will be diminished or eliminated.

- Cherniak, Transcript, at 3732-33; Corey, Transcript, at 3955-57, 3964-68, 4012-13; Rempel, Transcript, at 4744-45, 4750; Baptiste, Rowe, Franks, Transcript, at 4837-39; Allstate (R. Rogers), Transcript, at 2475

4.11 No fault systems of insurance promise, in return for the extinction or limitation of tort rights, speedy, certain and inexpensive delivery of first party benefits. In light of the evidence concerning the current delivery of no fault benefits, the Board considers it imperative that prior to implementation of product reform, there should be in place mechanisms to ensure that no fault benefits are in fact delivered in accordance with the insurers' obligations under the contract of insurance. The Board notes that there is a need even today for such mechanisms within the context of the current add on system of compensation. The need becomes critical if a no fault system is introduced that restricts or precludes access to the courts.

C. ALTERNATIVE DISPUTE RESOLUTION

1. Introduction

4.12 Alternative dispute resolution is a term often used to describe forms of dispute resolution other than court adjudication. In fact, included within the ambit of ADR is a whole spectrum of mechanisms, some of which are adjuncts to, or steps in, the process of litigation. An example of the latter type of ADR mechanism would be the New Jersey system of mandatory court-annexed arbitration (Exhibit 8.8).

4.13 The terms of reference contained in the Order in Council give little guidance concerning the type of ADR mechanism in respect of which a cost impact is to be estimated. The mechanism is described simply as "involving mediation and, if necessary, binding arbitration for the settlement of no fault compensation". "Mediation" or "conciliation" (the terms are often used interchangeably) is a process in which a neutral third party assists parties to a dispute to reach a negotiated settlement. Although mediation may be compulsory, it is generally non-binding. The mediator does not render a decision. "Arbitration" is an adjudicative process in which a dispute is submitted to a neutral third party, who is not a judge. The arbitrator receives evidence, hears arguments and renders a decision. Arbitration may be statutory or contractual, binding or non-binding, voluntary or mandatory.

4.14 The Board heard much evidence concerning the various forms of ADR, and the utility of, and need for, such mechanisms in Ontario as means of resolving disputes relating to motor vehicle compensation. Perhaps because of the lack of precision in the terms of reference, very little evidence that was presented dealt directly with the cost impact of an ADR mechanism. The evidence relating to ADR is aptly summarized in the Submission of Board Counsel (at 4/1-4/69). The evidence will not be reviewed in detail in this Report.

4.15 In order to fulfill its mandate, the Board must make certain assumptions concerning the elements of an appropriate mechanism "involving mediation and, if necessary, binding arbitration for the settlement of no fault compensation". Before describing the major features of such a mechanism, however, it will be useful to describe briefly two possible ADR models, of a number of models described in evidence before the Board.

2. Potential ADR Models

4.16 While the insurance industry has been studying a form of ADR for first party no fault benefits and third party claims (the IBC Alternative Dispute Resolution Project Group), and although insurers supported the concept of

ADR in general, no detailed plans for a mechanism were put before the Board. Nor did the Industry Coalition advocate that the industry review committee proposal it had supported before the Osborne Inquiry be adopted.

- R. Rogers, Transcript, at 2192
- Osborne Inquiry Report, at 608-11

4.17 The Board heard evidence relating to a number of ADR mechanisms in force, both in Ontario (the Private Court, Exhibit 13.5), and in U.S. jurisdictions. Some mechanisms, such as the Private Court, are obviously, for cost reasons, ill-suited to the resolution of no fault benefit disputes. The evidence relating to the U.S. models was sketchy; however, evidence concerning the system of conciliation/arbitration administered by the New York Department of Insurance was somewhat more detailed. The New York system commended itself to the Board as a possible model. In addition, the Arbitrators' Institute of Canada (Ontario) Inc. put forth an ADR model that it believed could form the basis for resolution of disputes concerning no fault benefits.

(a) The Arbitrators' Institute of Canada Plan

4.18 The Arbitrators' Institute of Canada (Ontario) Inc. (AIC) is a section of the Arbitrators' Institute of

Canada Inc. It is a not-for-profit corporation incorporated under the laws of Ontario. The Board of Directors consists of 20 elected members, of which 8 are appointed by the Board to an Executive Council. The staff consists of the Executive Director, Mr. Sherman, and a bilingual secretary. The AIC is a professional organization for arbitrators, which presents courses, sets standards, and provides a code of ethics. Persons are accepted as arbitrators by a Selection Committee on the basis of experience in a particular field and successful completion of two courses offered by the AIC. The AIC services arbitration cases, and recommends arbitrators to persons wishing resolution of a dispute. Arbitrations carried out by the AIC are subject to the Arbitrations Act, R.S.O. 1980, c.25.

- Sherman, Transcript, at 957-59, 1109-10

4.19 The AIC submitted a plan for the resolution of automobile insurance disputes. The details of the plan, as outlined in Exhibit 11.4, are sketchy. It was clear that the AIC would require additional resources if the plan were to be made operative throughout the Province. Further details were provided by the AIC in Exhibit 11.6, which was filed subsequent to the appearance of witnesses for the AIC before the Board. Exhibit 11.6 was not subjected to cross-examination.

4.20 The plan is designed for "minor cases", involving less than $25,000. Because it is contemplated that procedures would be "streamlined", and arbitration hearings limited to a 5 hour session, the plan was conceded to be inappropriate for cases involving major economic loss, in which pre-trial proceedings would be necessary. Mr. Consky indicated, however, that the plan could be adapted for larger cases so long as the issues were sufficiently narrow that the case could be disposed of in approximately 5 hours. The plan could be either voluntary, or mandatory in accordance with the terms of the insurance contract or specific legislation.

- Consky, Sherman, Transcript, at 964-65, 972-75, 998-99, 1019-20

4.21 The AIC plan contemplates a two stage process consisting of (1) fact settlement and mediation, and (2) arbitration. During the first stage, a meeting would be held to mediate the dispute. Parties with authority to settle the dispute would be required to attend. Counsel would not be required, but parties could be represented by counsel. The AIC, in fact, would encourage representation by counsel: "counsel provides a vital function in the hearing and in the mediation, and without that knowledgeable presence I think that the parties are disadvantaged".

- Sherman, Transcript, at 975-77, 1041-42

4.22 Mediation would not be binding. Should settlement not occur, the mediator would assist the parties to define and narrow the issues and to agree on evidence to go to arbitration. The parties would be free to proceed instead to court, and indeed might be advised by the mediator to do so.

- Consky, Transcript, at 1019-20

4.23 If arbitration is chosen, an arbitrator would be appointed and the hearing held within a specified period of time. A preliminary meeting would be necessary to settle matters of procedure and evidence; alternatively procedures could be specified by legislation. In order to contain costs, the arbitration would take place during a 5 hour period.

- Sherman, Transcript, at 972-75

4.24 The arbitrators would have authority to make interim awards. Decisions would be required to be issued within a specified time period. The AIC proposed that decisions be binding, with a right of appeal available only for cases over a certain monetary limit. The AIC envisaged that most disputes could be resolved within 4 to 6 months.

- Consky, Sherman, Transcript, at 978, 984, 1003-04

4.25 Mediators and arbitrators would be selected originally from a roster of lawyers maintained by the AIC. The mediators and arbitrators would be pre-approved by a committee consisting of insurers, consumers (the CAC), the Bar and the AIC. The roster could be expanded at a later date to include persons knowledgeable in such areas as medicine and rehabilitation.

- Sherman, Transcript, at 1011-12, 1116, 1119

4.26 The AIC would administer the plan, either alone or in cooperation with other ADR organizations, from its office in Toronto. The AIC saw no need for administrative offices outside Toronto, but conceded that there would be difficulty in servicing insureds outside the Metropolitan area unless mediators and arbitrators were available.

- Sherman, Transcript, at 1045-47

4.27 Under the AIC plan, the costs of the service would be borne by the parties. The costs were estimated as follows: (1) $295 per party for a 90 minute mediation; (2) $975 per party for a 5 hour arbitration hearing; and (3) an administrative fee to cover a hearing room and miscellaneous disbursements. Alternatively, the plan could be funded by government or by insurers.

- Exhibit 11.4, as modified by Exhibit 11.6, at 9-11

(b) New York Conciliation/Arbitration Program

4.28 In New York, disputes between insureds and insurers concerning the denial of first party claims are governed by legislation designed to encourage delivery of first party benefits. This legislation provides, inter alia, for a dispute resolution process consisting of conciliation and arbitration. Section 5106 of the New York Insurance Law reads in part as follows:

> **s. 5106. Fair claims settlement**
>
> (a) Payments of first party benefits and additional first party benefits shall be made as the loss is incurred. Such benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained. If proof is not supplied as to the entire claim, the amount which is supported by proof is overdue if not paid within thiry days after such proof is supplied. All overdue payment shall bear interest at the rate of two percent per month. If a valid claim or portion was overdue, the claimant shall also be entitled to recover his attorney's reasonable fee, for services necessarily performed in connection with securing payment of the overdue claim, subject to limitations promulgated by the superintendent in regulations.
>
> (b) Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party benefits, or additional first party benefits, the amount thereof or any other

> matter which may arise pursuant to subsection (a) hereof to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.
>
> ....

4.29 The dispute resolution process is prescribed by Regulation No. 68 and is administered by the New York Insurance Department. Conciliations are conducted by department staff. Arbitrations are conducted by the American Arbitration Association (AAA).

4.30 Under Regulation 68, insurers are required, within 10 business days of a determination that no fault benefits are not payable, to send an applicant for first party benefits a denial of claim form specifying the reason for denial of benefits. Claimants who wish to dispute the denial of claim may initiate the conciliation/arbitration process by filing the denial of claim form (or a prescribed no fault arbitration request form), together with $40, with the Department of Insurance.

- Reiersen, Transcript, at 662-63

4.31 Insurance department staff review all requests and attempt initially to resolve each dispute by telephone. Each insurer is required by regulation to designate a contact person within each claims office with authority to bind the insurer by telephone. Mr. Reiersen, a Chief Examiner with the New York Department, who appeared before the Board at Board Counsel's request, indicated that department staff are successful in achieving resolution in 40% to 45% of disputes within two weeks by telephone.

- Reiersen, Transcript, at 658

4.32 If conciliation cannot be effected within 30 days, the dispute is referred to one of four arbitration forums, as follows (Exhibit 7.7, at 39-40):

1. Expedited Arbitration - Determines questions of eligibility or coverage. Arbitrators are not authorized to direct the actual payment of benefits.
2. Regular AAA Arbitration - Determines loss of earnings and other "reasonable and necessary" expenses resulting from the accident.
3. Health Services Arbitration - Involves determination, usually by a panel of three medical practitioners, as to whether medical services were related to the accident.
4. Insurance Department Arbitration - Deals with disputes concerning whether and how much a claim is overdue, or whether the correct amount of interest or attorney's fees was assessed in respect of overdue claims. These issues are usually decided on the basis of written submissions by the parties without a hearing.

4.33 There is a right of appeal from expedited, regular AAA, and health services arbitration to a master arbitrator, who is selected by the AAA. The master arbitrator does not conduct a review de novo of the facts, but rather reviews the award to ensure that, inter alia (1) it was not awarded in an arbitrary or capricious manner; (2) it was correct as a matter of law. The award may be affirmed, affirmed and modified, vacated entirely, or vacated and remanded to a new hearing. In addition, it would appear that a party has a right to a trial de novo where the master arbitrator's award exceeds $5,000, exclusive of interest or attorney's fees, as well as a right to go to court on natural justice grounds.

- Exhibit 7.7, at 39-40, 45; Reiersen, Transcript, at 804-05; Schnitter, Transcript, at 860

4.34 Initially, arbitration panels were staffed by plaintiff's attorneys. This resulted, according to Mr. Reiersen, in too many cases being decided against insurers. A system whereby health disputes were handled by the Workers' Compensation Board was also attempted, but discarded because of delays in the resolution of disputes. As of July, 1988, arbitrations are carried out by twelve full-time paid arbitrators under the auspices of the AAA. Arbitrators are chosen by a Screening Committee consisting of insurer representatives and representatives of the legal profession. Arbitrators are chosen on the basis of experience and impartiality (they cannot have a negligence practice or be affiliated with an insurance company). Arbitrators have access to independent health consultants and specialists, selected by the AAA, who will conduct medical examinations requested by the arbitrator and report back with the results thereof.

- Reiersen, Transcript, at 655-61

4.35 The cost of the arbitration process is borne primarily by the insurance industry. The cost of participation in the conciliation/arbitration process to the no fault claimant is minimal. Apart from the $40 fee paid by a claimant upon a request for arbitration (which payment is returned by the insurer if the claimant achieves any degree of success), the claimant is responsible only for the fees charged by his or her attorney for the arbitration. Moreover, if the claimant is successful at arbitration, the insurer is responsible for the plaintiff's reasonable attorney fees. Regardless of success, the plaintiff is never responsible for the insurer's costs.

- Reiersen, Transcript, at 664, 804-06

4.36 Mr. Reiersen stated that the Department of Insurance processes about ten thousand requests for arbitration a year. He stated that the process is working well, a view that was confirmed by a New York attorney called by Board Counsel, Mr. Schnitter, who testified that both insurers and insureds view the procedure positively. Mr. Schnitter estimated that it was possible to have a case resolved in as little as 2 to 3 months, although some cases could require a year.

- Reiersen, Transcript, at 664, 803
- Schnitter, Transcript, at 858-61, 895

3. Essential Features of an ADR Mechanism

4.37 Before turning to the issue of the cost impact of ADR, it is necessary to describe the features of an ADR system that, in the Board's view, would constitute an appropriate way of ensuring speedy and inexpensive delivery of no fault benefits. It should be emphasized that, in so doing, the Board is not concerned only to minimize the costs to insurers of resolving no fault disputes. A major concern of the Board is to facilitate access to such benefits by insureds whose rights to recover damages in tort may have been restricted or eliminated by the introduction of a no fault system.

4.38 1. The mechanism should be restricted to the resolution of disputes concerning entitlement to and assessment of no fault benefits. The Board does not believe that any case has been made for the expansion of the function of an ADR mechanism beyond that contemplated by the terms of reference -- that is, the resolution of no fault disputes. The evidence of The Honourable Judge Gordon Killeen, Senior Judge of the District Court, Middlesex, indicated that the courts are neither unduly burdened by motor vehicle accident litigation, nor unable to process cases in a timely manner. Moreover, the Board accepts that arbitration, with its streamlined procedures, may be inappropriate for the resolution of many difficult questions of liability and personal injury damage assessment. The Board specifically rejects the suggestion that ADR should be used, in a threshold system, to determine the question whether a particular injury meets the threshold. This, in the view of the Board, is a serious matter involving statutory interpretation, which should be determined judicially.

- Killeen, Transcript, at 5388-94
- Cherniak, Transcript, at 3716-17
- Graham, Transcript, at 1227-30

4.39 2. In all cases where the amount in dispute is less than $25,000, non-binding mediation should be available at the option of the insured. The evidence of Messrs Reiersen and Schnitter of New York is that mediation is very effective in resolving disputes at an early stage. Evidence filed with the Board relating to the experience of the AAA with a mediation plan similar to that proposed by the AIC suggests similar success.

- Exhibit 11.5, at 2

4.40 3. If mediation does not result in settlement of the dispute, arbitration should be available at the option of the insured. Insureds should not be compelled to submit their dispute to arbitration, but, rather, should have the option to seek resolution of the dispute in court. Evidence before the Board indicated clearly that the success of an arbitration process involving relatively informal procedures depends upon the cooperation of the parties and their willingness to narrow issues in order to secure a speedy resolution of disputes. The Board believes, however, that, particularly where the amounts in dispute are relatively small, it will be in the interest of insureds to submit their claims to arbitration because of the advantages in terms of cost and time.

- Graham, Transcript, at 1186-87, 1243-45
- Consky, Transcript, at 998-99
- Schnitter, Transcript, at 843-45

4.41 A further reason against requiring insureds to submit to arbitration is that, under the referred systems, disputes relating to no fault benefits could involve very complex issues and very substantial amounts of money. Even in New York, where the maximum amount available in first party benefits is $50,000, participation in arbitration is voluntary on the part of the insured. The Board is satisfied, on the basis of the evidence before it, that many disputes concerning no fault benefits will involve complex issues that deserve the procedural protections of traditional litigation.

- Consky, Transcript, at 1019-21, 1089; Cherniak, Transcript, at 3762-66; Baker, Transcript, at 6639-45, 6704-06

4.42 4. Arbitration should be binding. Apart from judicial review, there should be a right of appeal only to a master arbitrator, on limited grounds. In coming to this conclusion, the Board is concerned to balance the objectives of cost savings and expedition, on the one hand, and the requirements of due process, on the other. The Board believes that provision of a limited right of appeal to a master arbitrator not only serves as a safety net for individual parties, but will enhance the quality and consistency of arbitration decisions generally.

4.43 5. Parties to a dispute should have the right to be represented by counsel, but legal representation should not be a prerequisite to participation in mediation or arbitration proceedings. The Board notes the position of the Canadian Bar Association - Ontario (CBAO) that legal representation should be mandatory if arbitration is binding. Professor Graham and Mr. Consky testified that experienced mediators and arbitrators can serve to mitigate somewhat the effects of inequality of bargaining power. Moreover, while legal representation is desirable and may well produce a better result, insureds settle claims every day without legal assistance. While the Board would not require legal assistance, it is of the view that the cost rules that are proposed to govern the mediation/arbitration process will assist those claimants who wish to secure legal representation (paragraph 4.44).

- CBAO, Submission, at 17
- Graham, Transcript, at 1207-09
- Consky, Transcript, at 977-78

4.44 6. The cost of the ADR system should be borne primarily by insurers. Insurers supported ADR before the Board, and, to the extent that legal costs are reduced and disputes resolved expeditiously, they will stand to benefit from its introduction. Moreover, many insurers recommended that insurers bear the cost of ADR. More important, however, is the need to facilitate access to no fault benefits by removing cost disincentives. Accordingly, the Board has concluded that, as under the New York system, the only costs that claimants should be required to bear are a modest fee upon application for mediation/arbitration and the cost of legal representation, if any. If the mediation results in a settlement in favour of the claimant, or if the plaintiff succeeds at arbitration, the insurer should be required to pay the reasonable legal costs of the insured. An unsuccessful claimant should in no event be responsible for the legal costs of the insurer. The Board considers this "one way" cost rule necessary in order to encourage insureds to resort to mediation/arbitration. The Board notes that such a cost rule, by increasing incentives to choose arbitration over traditional litigation, should result in cost savings.

- Industry Coalition, Argument, at 14-15; State Farm, Submission, at 5; Progressive, Argument, at 3

4.45 7. Arbitrators should possess expertise and independence, and should have training to act as arbitrators. Mediators also should have relevant experience and training.

4.46 8. The ADR mechanism should be available across the Province. Insureds outside the major cities should have equal access to an inexpensive and expeditious form of dispute resolution. The evidence of the AIC suggested that providing arbitration and mediation across a geographically large area can involve administrative difficulties and cost. The AIC expressed the view, however, that, if the demand were present, mediators and arbitrators could be available in county towns, and that the system could be administered from a central office.

- Consky, Transcript, at 1045-47

4.47 9. The ADR system should recognize the special needs of injured persons requiring rehabilitation. Problems of delivery appear to be particularly acute in relation to rehabilitation benefits. The evidence confirmed Mr. Justice Osborne's findings that, in the absence of agreement and notwithstanding the position of the claimant's medical advisor concerning the need for rehabilitation, insurers, through their medical advisors, have and exert an effective power of veto over rehabilitation treatment. It should be noted that Mr. Justice Osborne recommended that the opinion of the insured's medical advisor as to rehabilitation, and of rehabilitation counsellors, should be of primary evidentiary significance. The only recourse currently available to a claimant who has been denied benefits is to litigate. The evidence suggested that lawyers now provide the major means of access to rehabilitation benefits.

- Osborne Inquiry Report, at 162-63
- Corey, Transcript, at 3925
- Galway, Rempel, Transcript, at 4756
- Baptiste, Transcript, at 4813-15, 4818-19

4.48 Rehabilitation witnesses strongly endorsed the recommendations and conclusions of Mr. Justice Osborne concerning the provision of rehabilitation benefits. They identified, and the Board endorses, the following characteristics of a system that would provide access to such benefits.

a. The decision concerning entitlement to rehabilitation benefits should be made by an independent third party, not the insurer. This function could be performed by an arbitrator or a panel of arbitrators.

b. There should be an independent assessment of the rehabilitation needs of the injured person, performed by professionals with experience in dealing with the type of injury in question. Dr. Franks testified, however, to a severe shortage in the Province of professionals with an understanding of head injury. Dr. Corey and Mr. Dailey of Progressive confirmed difficulties relating to the accessibility of medical experts to examine and testify concerning the rehabilitation needs of injured persons.

- Franks, Transcript, at 4802, 4823-24
- Corey, Transcript, at 3959-61
- Dailey, Transcript, at 4071-72

c. *Decisions concerning rehabilitation should be made quickly*. Early access to rehabilitation was stated to be essential to the success and cost effectiveness of rehabilitation programs. The abovementioned difficulties relating to the accessibility of medical personnel, however, make an early decision problematic. In response to questions by Mr. Galway, Counsel for the Industry Coalition, Dr. Corey stated that he doubted whether a decision within 60 days would be possible. He noted that the Workers' Compensation Board, with in-house medical personnel, takes between 3 and 6 months to render a decision.

- Corey, Transcript, at 3923, 3946-47, 3959-61; Baptiste, Transcript, at 4815-16
- Corey, Transcript, at 3960, 4011-12

d. *Rehabilitation treatment should not await a decision concerning entitlement*. Mr. Justice Osborne recommended that the insurer should be required to absorb the expense of rehabilitation pending resolution of any dispute -- a view that was echoed by rehabilitation witnesses.

- Osborne Inquiry Report, at 163; Corey, Transcript, at 3933-34, 3946-47, 4011, 4012; Baptiste, Transcript, at 4820

D. ADDITIONAL DELIVERY MECHANISMS

4.49 The Board has concluded that, in addition to an ADR system embodying the elements identified above, there should be available further mechanisms, similar to those utilized in New York, to encourage prompt delivery of no fault benefits. The following testimony of Mr. Reiersen of New York outlines the elements of, and the need for, a comprehensive system of enforcement (Transcript, at 662-64, emphasis added):

> In New York we have very -- to me the most important thing of no-fault is prompt payment of benefits. It is a sin to have to wait two or three years to get your benefits and we get the benefits out to the people -- within two months they start getting benefits. We have very elaborate claim practice rules in our regulations, regulation 68. We enforce those regulations.
>
> [Q] Now, those regulations, as I understand it, enable you to in effect police the insurance industry to make sure these claims are paid promptly and properly; is that right?
>
> [A] We have had to over the years, first we had very broad guidelines but then we found that in order to fine insurers for improper behaviour we had to make those guidelines very precise and the regulations detail within five days you do this and once you get this back you have ten days to do this and it lays out

the process.

[Q] Sounds like a fairly elaborate process that you have had to devise.

[A] Yes.

[Q] Was that because these claims weren't being paid by the insurers when the no-fault plan was first introduced?

[A] Initially insurers made the mistake of using the same people who have been the claims persons on a real adversarial system, the old tort system, and they used these same individuals to process no-fault. And those attitudes are hard to change. Even though our regulations at that time said you are supposed to treat the claimant as your friend, it didn't really hit and we found that we needed these regulations. We also, as I say, have -- we have a very effective market conduct unit within our bureau. They sit right next to the concilators, I have a conciliation unit which is conciliating the no-fault disputes.

[Q] Right.

[A] Whenever there is a problem with a carrier we notify the market conduct unit, they do an investigation to make sure that that carrier is complying with the regulations, if they are not they get fined a substantial amount of money.

I would say today we have very few problems. Today in New York most auto carriers treat no-fault like an accident and health coverage. Most of them today are in compliance.

[Q] Is there still a 2 percent per month penalty on late payment of no-fault benefits?

[A] Yes. And you can still recover your attorney's reasonable fee.

[Q] On an arbitration if your successful in recovering one dollar?

[A] Right. You have a very simplified arbitration mechanism and I think that claimants have very few problems collecting benefits.

4.50 A similar enforcement scheme should be adopted in Ontario. The elements of the scheme should include:

(a) Specific and precise claims practice procedures. Claims should be required to be paid within a specified number of days.

(b) Substantial interest penalties for late payment of no fault benefits. The Board considers that 2 percent per month, the amount charged in New York, would be appropriate in the present financial context. Evidence indicated that large interest penalties are quite effective, while lesser penalties, such as those imposed in Michigan, tend to be less effective.

- Reiersen, Transcript, at 664; R. Miller, Transcript, at 1768-69; Kelaher, Transcript, at 2202-03; Creamer, Transcript, at 1275-76; Perry, Transcript, at 5058; Hunter, Transcript, at 6862-65

(c) A requirement that insurers send a prescribed denial of claim form to no fault claimants within a specified time frame, stating clearly the reasons for denial and advising the claimant of the right to seek, and the way to access, mediation/

arbitration. (See New York Denial of Claim Form, appended by Royal to its Exhibit 21.5.)

(d) A right in a successful claimant to reimbursement of reasonable legal fees incurred in attempting to secure benefits to which he or she is entitled.

(e) Authority to investigate non-compliance with claims practice requirements, and to impose substantial penalties.

4.51 The Board has considered whether legislation should be enacted authorising "bad faith" tort actions against insurers who fail to fulfill their no fault obligations. The evidence of Mr. Hunter of the CAC was that such actions, which give a right to claim punitive damages, are very effective in U.S. jurisdictions in deterring improper activity. The Board makes no recommendation concerning this matter, beyond stating that the desirability of such actions should be considered in the event that, even with the implementation of the abovementioned enforcement scheme, current delivery problems persist.

- Hunter, Transcript, at 6786, 6896-97, 6924-26

E. CONCLUSIONS

4.52 The Board has concluded that the most suitable ADR system for Ontario -- one that would incorporate the essential features outlined in paragraphs 4.37 to 4.48 -- is a system of mediation/arbitration similar to the New York system of no fault dispute resolution, whereby mediation is provided by government at a nominal cost to insureds and arbitration is provided through the auspices of an agency external to government, such as the AAA.

4.53 The Board notes that there was a great deal of support among participants in the Hearing for adoption of a model similar to the New York system. Not only did such organizations as ARCH and the CAC support this approach, but insurers endorsed it as well.

- Progressive (Dailey), Transcript, at 4085-87, 4178, 4193-94; Progressive, Submission, at 3; State Farm (Perry), Transcript, at 5058-59; Industry Coaltion, Argument, at 14-15; CAC, Final Argument, at 5; ARCH, Final Submission, at 15-17

4.54 The Board's support for a government-administered ADR system derives primarily from its view that ADR should be part of an overall scheme for the enforcement by government of insurer obligations with respect to no fault benefits, incorporating the measures outlined in the previous section of this chapter. The provision of mediation services by the body charged with overall enforcement of no fault delivery should create an environment in which the incentives for insurer compliance with no fault obligations are maximized, and coordinated efforts may be adopted in respect of non-compliance.

4.55 A no fault claims practice division should be established within the appropriate regulatory body, charged with enforcement of no fault benefits delivery. This division should include a mediation section, staffed by employees of the regulator, who should be trained in techniques of mediation and who should attempt to resolve no fault disputes.

4.56 In order to avoid the creation of a bureaucracy, it would be preferable if arbitration could be administered, under the direction of government, by an outside arbitration agency similar to the AAA, which performs this function in New York. The Board makes no finding with respect to the appropriate body to undertake this function, but notes that the AIC would appear to be willing to assume such a role. The administrative capacity of the AIC may be unequal to the task at the present time, however. The evidence indicated that the AIC has at present an office staff of two. Access to the system outside Metropolitan Toronto is by way of a single WATS line. It is clear that if the AIC is to perform a function throughout Ontario similar to that of the AAA in New York, its administrative capacity would have to be expanded.

4.57 The AIC stated that it would require at least 4 months to set up an ADR system:

> This lead time will allow AIC to obtain premises, to utilize the expertise of its American Arbitration Association advisors, to employ and train office staff, and to operate training courses for additional arbitrators.

Professor Graham stated that "if the political will is there and the treasury is there", it would be possible to set up an ADR system within 6 months.

- Exhibit 11.6, at 12, 14
- Graham, Transcript, at 1242

4.58 As in New York, the arbitration agency could provide administrative services, hearing rooms, and support facilities, as well as arbitrators to staff arbitration panels and master arbitrators to hear appeals. Arbitrators should be subject to the approval of a committee comprising representatives of consumers, the insurance industry, the Bar, the arbitration agency, and government. Arbitrators would require special training, which could be provided by the arbitration agency in accordance with government guidelines.

4.59 With respect to the particular requirements of persons requiring rehabilitation treatment, the Board suggests that special "fast-track" panels be set up, on which rehabilitation experts would be represented. These panels should have the power to make an interim award upon the claimant's establishing a *prima facie* case, on the basis of medical evidence, that rehabilitation treatment is necessary. This would permit rehabilitation to proceed pending final resolution of the dispute. The Board notes the difficulties concerning availability of medical personnel, and refers to the provision of New York Regulation 68, which requires the AAA to maintain a roster of independent health consultants. These consultants are available, at the request of an arbitrator, to review medical evidence or to examine the injured party, and to report back to the arbitrator. Every effort should be made to secure the availability of professionals with specialized expertise to serve a similar function.

4.60 The Board appreciates the difficulties involved in establishing, on a Province-wide basis, a system of mediation/arbitration and associated enforcement mechanisms. Mediators and arbitrators will have to be recruited and trained. Streamlined procedures will have to be devised. Legislation will be necessary to deal with a myriad of issues, including matters of jurisdiction and appeal. Nevertheless, the Board reiterates its conviction that, if existing tort rights are to be circumscribed, such mechanisms must be in place and operational prior to the implementation of product reform.

F. COST IMPACT OF ADR

4.61 The Order in Council did not specify the ADR mechanism to be costed. Accordingly, very little evidence was introduced concerning the cost impact of an ADR system. In its Argument, the Industry Coalition stated as follows with respect to the cost impact of ADR (at 15):

> While the evidence is incomplete on the details of costs to implement and run [an ADR] system, it is submitted that the evidence is sufficient to establish at least the following. First, the evidence from New York is that Alternative Dispute Resolution works well. Second, the evidence of both Mr. Justice Osborne and the company panels was that Alternative Dispute Resolution is needed and should work well in the delivery of first party benefits. Third, Alternative Dispute Resolution has the advantage of being

> flexible. Thus, for example, Alternative Dispute resolution allows the payment of benefits to be an ongoing process. It is flexible enough to allow for modifications due to changing circumstances. Fourth, Alternative Dispute Resolution as a system is faster than the Court system. Fifth, Alternative Dispute Resolution, as a system, cannot possibly cost more than the Court system.

Having made certain assumptions concerning the features of an appropriate ADR system, the Board can offer the following additional observations.

4.62 It is clear that a mechanism of the sort recommended by the Board would result in some of the costs of resolving no fault disputes being transferred from the public purse, which supports the court system, to insurers, who would fund the ADR system. Depending on the cost efficiencies of ADR, this could result in increased premiums as these costs are passed on to insureds. At the same time, it is the expectation of the Board that a system similar to that in New York can be effective, through mediation, in resolving a large number of disputes at an early stage, prior to the institution of litigation. Moreover, an arbitration process involving simplified procedures and voluntary participation by insureds, should have advantages in terms of time over the courts for the resolution of relatively minor disputes. It seems reasonable to expect that such a system will result in some reduction of legal fees -- a cost advantage that could well offset the costs of an ADR system incurred by insurers.

4.63 The evidence of Mr. Reiersen does describe in general terms the cost of the type of ADR system recommended by the Board, in the context of New York State. Mr. Reiersen testified that the overall cost of New York's conciliation/ arbitration program is in the area of $2.5 million (U.S.), exclusive of legal costs incurred by insurers and insureds. This breaks down as follows: the cost of the conciliation program is approximately $500,000 (a figure that does not cover cost allocations for overhead); the cost of the AAA arbitration program is $2 million.

- Reiersen, Transcript, at 803-04

4.64 The conciliation program run by the Department of Insurance employs 9 conciliators. The major portion of the cost of the program is covered by the $40 fee assessed against each applicant for conciliation (this amount is returned by the insurer in the event the insured receives payment pursuant to the conciliation process). The Department receives 10,000 applications a year, which produces $400,000, and receives additional revenue from penalties assessed against insureds in clear cases of abuse.

- Reiersen, Transcript, at 800-01, 803-04

4.65 The arbitration program is run by the AAA, which provides arbitrators, master arbitrators and medical consultants, as well as administrative offices and facilities for arbitrations. Since July 1988, arbitration has been carried out by 12 full-time arbitrators, who are paid $75,000 each per year. The estimated $2 million cost of the arbitration program is assessed out to insurers on the basis of premiums written.

- Reiersen, Transcript, at 661, 664-65, 744-45

4.66 Mr. Reiersen stated that he is satisfied with the costs of the program in relation to the benefits obtained, expressing the view that, "It's certainly cheaper than court ...". While it is dangerous to attempt to project the cost of such a program in Ontario on the basis of the New York experience, the evidence of Mr. Reiersen does provide some guidance as to the general magnitude of this cost.

- Reiersen, Transcript, at 744

5. IMPACT OF NO FAULT SCHEMES ON ACCIDENT RATES

A. INTRODUCTION

5.1 An issue that assumed major importance during the Hearing was whether a change in the liability rules attendant upon introduction of a no fault system would result in an increase in accident and fatality rates. This issue is relevant to the question, referred to the Board, concerning the average prices that would be charged for each of the referred systems. As Professor Jack Carr, a Professor of Economics at the University of Toronto, pointed out (Transcript, at 5846-47):

> ... to the extent that there's increased accident rates that will result from no-fault, the savings from no-fault will be reduced. All the actuarial reports I read, Tillinghast, Wyatt and State Farm, all assume as you change the liability rules, there will be no change in the frequency of accidents.

5.2 An increase in accidents would affect also the issue of future price stability, referred to the Board by the Order in Council and discussed in Chapter 7. Moreover, the issue touches upon another matter referred to the Board -- that is, "administrative barriers that exist in relation to the system that could result in significant additional costs either in implementation or in the continuing operation of the system".

5.3 A fundamental principle of the current tort liability system is that persons are responsible for harm caused to third parties by their negligent conduct. All three no fault systems referred to the Board involve, to varying degrees, a change in the current liability rules. The two threshold systems (Options 1 and 2) relieve an at fault insured of liability to third parties for non-economic loss, where the injury sustained is not sufficiently serious to meet the specified verbal threshold. The insured remains liable, however, for all economic loss, as well as for non-economic loss in respect of injuries that meet the threshold. In the case of an accident, both the at fault party and the not at fault party may claim from his or her own insurer the no fault benefits available under the policy.

5.4 Under the choice system (Option 3), the liability rules are dramatically altered. The choice no fault option abolishes entirely the responsibility of an at fault insured to third parties for both economic and non-economic loss. Each party to an accident would make a claim against his or her own insurer for economic loss in accordance with the schedule of no fault benefits.

5.5 As pointed out correctly by Professor Carr (Transcript, at 5806-07), the choice tort option is also, despite its name, first party insurance. Under this option a person is not responsible for damage done to third parties. In the event of an accident, the recourse of an insured is against his or her own first party insurer. The presence or absence of fault on the part of the insured, while relevant, serves only to determine entitlement to the higher level of first party benefits available under the choice tort policy.

5.6 Both Professor Carr and Professor George Priest of Yale University noted an essential difference between the choice plan referred to the Board under the Order in Council and that originally advocated by Professor Jeffrey O'Connell. Under the original O'Connell choice plan, a driver with a choice tort policy could sue another driver so insured. In the words of Professor Priest (Transcript, at 6250):

> The choice plan of the Order-in-Council is quite a bit different, as I mentioned, because it really is not a true fault plan. It is a plan in which the faulty driver or the negligent driver does not -- will not face higher premiums as a result of that faulty behaviour because of the first party character of the plan. That reduces some of the uncertainties of the O'Connell plan as between driver choice, but it also really presses -- means that one should analyze the Order-in-Council plan as if it is a pure no-fault plan

> with different benefit levels and one of which is conditioned upon showing negligence.
>
> So it's a very peculiar plan, one that I've never seen proposed in any academic literature nor have I ever heard of any country in the world even thinking about such a plan. But its operative characteristics will be somewhat different from the O'Connell and Calibrese, more genuine choice plans.

B. IMPACT OF CHANGE IN LIABILITY RULES

5.7 It was the position of FAIR, as advanced by Professors Carr and Priest, that the reduction or elimination of responsibility for damage caused to third parties, inherent in the no fault systems referred to the Board, would result in increased accident frequency, and that this factor should be considered in evaluating the three systems.

5.8 Both Professors testified that a system of liability based on fault or negligence, whereby a person is responsible for harm caused to a third party as a result of his or her negligent conduct, induces an appropriate standard of care and deters inappropriate conduct leading to accidents. It was argued that the introduction of a no fault system has two principal effects -- (1) a reduction in the standard of care, and (2) an increase in activity levels -- which, in turn, lead to increased accident rates.

- Carr, Transcript, at 5903-04, 5823-24
- Priest, Transcript, at 6436-37

5.9 In support of this proposition, based upon economic theory, FAIR relied upon a number of empirical studies that attempt to measure the effect upon accident rates of the introduction of no fault schemes. Reference was made in evidence to U.S. studies dealing with the effect of the introduction of threshold systems. In addition, FAIR referred to studies concerning the experience in "pure" no fault jurisdictions -- Quebec, New Zealand and the Northern Territory of Australia. Studies by Professor Gaudry, done for the Quebec Régie and for the Osborne Inquiry, were referenced, as was a recent study of the Quebec experience by Professor Rose Anne Devlin, filed as Exhibit 12.2. Studies concerning the impact of pure no fault in New Zealand and the Northern Territory of Australia, by R. Ian McEwin and Peter Swan, were filed as Exhibits 19.20 and 19.21, respectively.

1. Standard of Care

5.10 With respect to the assertion that the introduction of no fault systems would result in a reduction in the standard of care, it was suggested in cross-examination of Professor Carr, particularly by Counsel for the

Industry Coalition and the CAC, that liability insurance has already undermined the deterrent function of tort. It was further suggested that other mechanisms, such as surcharges, the desire to avoid injury to one's self and one's family, and penalties under the Highway Traffic Act and the Criminal Code, serve equally effective deterrent functions.

- O'Donnell, Transcript, at 5922-27, 6001-05
- Belobaba, Transcript, at 6079-93
- Strung, Transcript, at 5904-05
- Hunter, Transcript, at 6800-10

5.11 Professor Carr acknowledged the existence of a major debate in the law and economics literature concerning the effect of liability insurance on the deterrent function of tort, but maintained that, even with insurance, insureds have incentives to drive safely. Under the current system, inappropriate driving behaviour will result in the imposition of surcharges. Moreover, except for minimal no fault benefits, insureds will receive no compensation in respect of accidents in which they are at fault. In a no fault environment, he argued, surcharges cannot effectively be imposed, as insurers have no incentive to determine fault, and one's economic loss is compensated regardless of fault.

- Carr, Transcript, at 5925-27, 5932, 5995-96

5.12 Professor Carr testified that, while adoption of the choice (or any pure no fault) system would involve the greatest reduction in the standard of care, even threshold systems would affect the incentives to drive safely and so would result in a lower standard of care and higher accident rates. The extent to which the standard of care would be reduced would depend upon the extent to which persons were relieved of responsibility for the harm occasioned (Transcript, at 5993-98):

> The more you relieve them of the harm, the greater the effect on the standard of care.
>
> So if New York has -- New York relieves less of the responsibility, then there should be less of this problem.

5.13 It was the evidence of Professor Carr that, while most rational persons will be deterred from inappropriate behaviour by considerations of personal safety and criminal sanctions, the introduction of no fault would operate to reduce the standard of care primarily of persons "on the margin". He stated (Transcript, at 5998-99):

> What's important in economics is people on the margin. There are people who are what are called inframarginal, who you could change the standard of care by a lot and it won't affect them. There are some people sort of just at the margin now. When you lower the cost, they now drive a little faster.

> No one in his right mind wants to cause an accident. It's the guy who thinks, 'If I drive faster, I'm not gonna have an accident.' No one wants to cause an accident, but if people drive faster there will be more accidents. If you're less responsible for the harm you do, if you have less costs on you then in fact it's going to affect your driving behaviour.

2. Level of Driving Activity

5.14 Professor Priest agreed with Professor Carr that the introduction of a no fault system would result in a reduction in the standard of care, but questioned how important the impact would be. Professor Priest preferred to emphasize the second effect of no fault systems -- the change in the activity levels of high risk drivers (Transcript, at 6220-21):

> ... I would not emphasize in my understanding of these systems the specific incentives to avoid -- to drive more carefully, to keep both hands on the wheel or look more frequently in the rear-view mirror as between no-fault and fault jurisdictions, but rather the sorting among those that drive and the manner in which they drive facing large increases in insurance premiums in at least fault jurisdictions ...

5.15 Professor Priest noted that, within the insured population there is a substantial number of persons whose level of driving activity will be influenced by the premiums paid. Because, in fault jurisdictions, high risk drivers generally pay premiums that reflect the costs they impose upon the system, a certain percentage of high risk drivers is, in essence "priced out of the auto insurance market" or forced to limit its driving activity because of price.

- Priest, Transcript, at 6221

5.16 In no fault jurisdictions, on the other hand, because insurers are not faced with some of the costs imposed by high risk drivers, premiums for such drivers tend to be lower. As a result, the level of driving activity of this group increases. Professor Priest explained the phenomenon as follows (Transcript, at 6214-22):

> Now, under no-fault plans, certainly under a pure no-fault plan, but the point is more general, under even graduated no-fault plans, to the extent that they preclude litigation over fault, there is a diminution of interest by the insurer and, thus, a diminution of impact on the insured driver himself or herself of the costs that that driver imposes on other drivers.
>
> ....
>
> Because [no fault] systems cull out some set of losses that the high-risk drivers impose, their premiums will be less, though maybe by a small amount, less than the premiums they would face under a fault -- under a fault-based system. That will be true even with low monetary thresholds. It will be increasingly true with the thresholds characteristic of New York and Michigan, which of course preclude large amounts of litigation, and suggest potentially the reduction of large amounts of damages.

. . . .

> No-fault, the adoption of no-fault will -- is likely to, and I believe that it will ... reduce the premiums for those high-risk drivers relative to a fault jurisdiction that will lead to more driving by those individuals.

5.17 Professor Priest was confident that it is this phenomenon - the resorting of drivers and the increased level of driving activity by high risk drivers in no fault jurisdictions -- that underlies the increases in premiums in no fault jurisdictions, which various studies, including the 1985 United States Department of Transportation Study, indicate are rising much more quickly than in fault jurisdictions.

- Priest, Transcript, at 6219-20, 6246-47, 6260

5.18 Professor Priest also testified (Transcript, at 6220) that the theory that no fault leads to an increase in the level of driving activity on the part of high risk drivers is supported by empirical studies, which indicate an increase in accident rates and fatalities following the implementation of no fault systems.

5.19 The Industry Coalition, State Farm, and the CAC challenged Professor Priest's conclusions on two main grounds. First it was suggested that, within a regulated no fault environment, a system of surcharges could be developed and applied to high risk drivers. This contention is examined in Chapter 6 of this Report. Secondly, the reliability of, and the conclusions to be drawn from, the empirical studies, particularly the Quebec studies by Professors Gaudry and Devlin, were questioned.

3. Empirical Evidence

5.20 With the exception of the studies by Professor Devlin, Mr. McEwin and Mr. Swan, the empirical evidence referred to at the Hearing concerning the impact of no fault systems upon accident rates had been considered by Mr. Justice Osborne during the course of the Osborne Inquiry. In the Osborne Inquiry Report, Mr. Justice Osborne concludes (at 540):

> ... looking at the empirical evidence as a whole it is difficult to draw the conclusion that no fault has caused a significant adverse effect on accident rates. Nor does the evidence seem to suggest that tort liability exerts any statistically measurable effect on the level of safe driving. But this does not end the matter. The study done by Professor White and the observations of Professor Schwartz give force to the argument that the tort system still performs some modest deterrent function in the motor vehicle context, even if its impact is not empirically demonstrable.

5.21 Most of the debate in this Hearing surrounding the empirical studies centred on the Gaudry and Devlin empirical studies of the effect on accident and fatality rates in Quebec of the introduction of a pure no fault system of automobile insurance. Professor Carr dismissed the U.S. studies (some indicating that no fault does lead to an increase in accident rates and others suggesting no such effect) as "mixed and not very important".

- Carr, Transcript, at 5824-25, 5992-94

5.22 The two Australian studies dealing with the effect of no fault on accident rates in New Zealand and the Northern Territory of Australia (two pure no fault jurisdictions) were not the subject of much evidence. The Swan study (Exhibit 19.21) is a critique of the recommendations of the New South Wales Law Reform Commission in favour of a pure no fault system of motor vehicle accident compensation, and includes an econometric analysis of the New Zealand and Australian no fault schemes. With respect to the results of the econometric study, the author concludes as follows (Exhibit 19.21, at 106):

> The principal finding of the econometric study undertaken of the effects of the removal of the negligence system in New Zealand and the Northern Territory is that the death rate increased in a statistically significant fashion, although some indication of how

> robust the result is may have to await further work. Such a rise in the death rate is anticipated from the reduced incentive of potentially negligent accident victims to take adequate care under the 'no-fault' principle. In addition a whole variety of factors which affect these rates are identified and quantified. Nonetheless there is considerable room for further work to improve both the specification of the model and the quality of the data.

5.23 The McEwin study (Exhibit 19.20) also attempts to measure empirically the effect of the introduction of no fault insurance schemes, both of the pure no fault and modified no fault varieties, in various Australian States and in New Zealand. With respect to pure no fault schemes, the study concludes (at 17):

> While not too much weight should be placed on the size of the impact due to the problems involved in modelling road accidents, the results ... suggest that the abolition of the common law tort of negligence action was associated with a sixteen per cent increase in the number of road fatalities per head of population ... tort abolition increased the risk of a fatal accident by approximately 0.04 per thousand head of population. The results should concern those who discount the role that a negligence liability rule plays in promoting safety.

5.24 The study of accident rates in Quebec following the introduction of a pure no fault system, conducted by Professor Gaudry for the Régie, indicated that accidents involving property damage increased by 11%, accidents involving bodily injury (but not death) by 26.3%, and fatal accidents by 6.8%. In Professor Gaudry's study for the Osborne Inquiry, he suggested that, while the introduction of a no fault system had some impact on the Quebec motor vehicle accident rate, this impact was not quantifiable and was, moreover, small compared to the effect of two other changes that accompanied the introduction of no fault insurance. First, flat premium rating was introduced, which led to an increase in the driving population in general, and in the proportion of high risk drivers in particular. Secondly, compulsory vehicle damage coverage and administrative changes relating to compulsory insurance resulted in an increase in the number of insured vehicles, with a consequential reduction in the standard of care.

- Osborne Inquiry Report, at 536-38

5.25 The Industry Coalition suggested that, because Professor Gaudry was unable to separate the effect of the introduction of a no fault system from the effect of flat premium rating, the study does not support the position that introduction of no fault schemes will lead to a reduction in the standard of care and hence to more accidents. Professor Carr testified that the study is nevertheless relevant, as it indicates the impact on accident rates of a scheme that lowers insurance premiums for high risk drivers -- a characteristic, in his view, of no fault systems.

- Carr, Transcript, at 5828

5.26 FAIR relied heavily on a later study of the Quebec experience, conducted by Professor Rose Anne Devlin as part of her Ph.D. research at the University of Toronto. The study, entitled "Liability versus No-Fault Automobile Insurance Regimes: An Analysis of Quebec's Experience" (Exhibit 12.2), attempts to separate the effect of flat premium rating from the effect of a change in the liability rules. As indicated, this study was not available to the Osborne Inquiry.

5.27 Professor Devlin's two principal conclusions are as follows (Exhibit 12.2, at 36-37): (1) "there would be a shift from low-risk drivers to high-risk drivers on the road as a result of the insurance price changes accompanying no-fault"; and (2) "[a]verage care fell substantially after the introduction of no-fault causing a 9.94% increase in fatal accidents. The theoretical model indicates that switching from a liability based insurance system to a no-liability system will result in individuals choosing a lower level of care, ceteris paribus".

5.28 The Industry Coalition introduced no evidence challenging the Devlin study, noting only in Argument (at 30-31) that Professor Gaudry had not considered it possible to separate the effect of no fault from the influence of other factors, and that FAIR had not produced Professor Devlin to testify. The Board notes that the Industry Coalition relied on studies (for example, the AIRAC study) without producing the authors. The Board notes also that it is unclear whether Professor Gaudry's comments (Osborne Inquiry Report, Vol. II, at 24) relate to his inability to separate out the relevant factors in the context of his study, or to the impossibility of such a task in general.

5.29 The Devlin study was challenged by the CAC. Mr. Belobaba, Counsel for the CAC, referred to the large number of "hypotheses, assumptions, estimates, weighted variables and postulates." He questioned, in particular, Professor Devlin's assumption that drivers make choices with respect to the level of care, based on liability rules. Mr. Hunter indicated that he did not understand how Professor Devlin had separated the effect of no fault from that of flat premium rating. He also rejected Professor Devlin's findings of a 9.94% increase in fatalitites as "intuitively ... out of reasonable range."

- Belobaba, Transcript, at 6111, 6115-16, 6427 ff.
- Hunter, Transcript, at 6802-03

5.30 Professor Carr, who had served on Professor Devlin's oral examination committee for her Ph.D. thesis, defended the methodology (Transcript, at 6112-13, 6116-17). In response to a question by Board Counsel concerning the quality of the Devlin study, Professor Priest commented (Transcript, at 6357-58):

> It's the best paper done on this subject that I know about, best empirical study that has been completed, and it's making a big splash in the U.S.
>
> Again, I'm not sure -- I don't think it has been published yet, but this working paper version from the University of Toronto has been disseminated like wild fire in the United States, and it is quite an excellent study. The Gaudry study got a lot of attention, too, but I think this paper in many respects is superior.

5.31 With respect to Mr. Belobaba's challenge to Professor Devlin's assumption that drivers make choices as to the standard of care on the basis of liability rules, Professor Priest responded (Transcript, at 6436-37):

> Now, again, if I just may assert again, Mr. Belobaba, I think Miss Devlin's conclusions and implications can be explained in either of two ways, or some combination of the two.
>
> One is the point that you've been emphasizing throughout that change in liability rules or

> change in the structure of insurance affects how carefully drivers monitor the automobile or choose to drive. That's one, and I certainly can't reject that, and I would agree that that's a possible interpretation.
>
> It seems to me ... that to a great extent a more plausible explanation is that the adoption of no-fault in Quebec and the shift toward more even level of rating systems premiums, as between drivers according to age and sex had the effect of increasing the number of young male drivers in the driving population. Drivers who are known both in the United States and from earlier studies here in Ontario to have -- to be associated with a higher level of accidents and a higher level of risk. That is what I would call the activity level effect.
>
> And because insurance premiums drop for high risk drivers and go up for relatively low risk drivers, we have a different sorting of individuals within the insurance pool, and as a consequence here, as Miss Devlin has shown empirically, a higher accident rate both in terms of number fatalities, in terms of bodily injury claims and the like.
>
> I think that's a more plausible interpretation of the Devlin results, but it is not an interpretation that is at all contrary to the points you've been making about more specific care --

C. CONCLUSIONS

5.32 The ongoing debate concerning the effect of abolition of tort liability on accident rates cannot be resolved finally on the basis of the evidence presented to the Board. Nevertheless the Board considers that this evidence, some of which was not available to the Osborne

Inquiry, advances the debate.

5.33 With respect to the standard of care, the Board is prepared, like Mr. Justice Osborne, to concede that the tort system likely exerts some modest deterrent effect on driving behaviour, particularly on the behaviour of those "on the margin". The studies by Swan and McEwin appear to lend support to the proposition that a negligence liability rule does have some independent deterrent effect, particularly since the introduction of no fault systems in New Zealand and the Northern Territory of Australia was not accompanied by any change in the merit rating system. Both before and after the introduction of no fault in those jurisdictions, premiums were not merit rated or surcharged (Exhibit 19.20, at 2). The Board acknowledges, however, that the Swan and McEwin studies were not the subject of detailed examination at the Hearing.

5.34 The Board is persuaded that the study conducted by Professor Devlin, concerning the effect on accident rates of the introduction of a no fault system of insurance in Quebec, lends further credence to the proposition that no fault systems will result in an increase in accident frequency. The Board accepts the evidence of Professors Carr and Priest concerning the quality of the Devlin study. Moreover, the Board considers it intuitively obvious that a reduction in premiums charged to high risk drivers will lead to an increase in their driving activity and a corresponding increase in accident frequency. To the extent that the introduction of a no fault system will result in a levelling of premiums for high risk and low risk drivers, the possibility of an increase in accident frequency cannot be discounted.

5.35 The Board notes that the elimination of age and sex as rating and classification factors, as envisaged by section 33 of the Ontario Automobile Insurance Board Act, 1988, would exacerbate this effect by reducing premiums for a group of drivers traditionally considered to be associated with the highest level of risk -- young males -- and increasing premiums for lower risk categories.

5.36 As indicated, it remains to be determined whether the costs imposed by high risk drivers on society can, as contended by the Industry Coalition and the CAC, be attributed to such drivers under a no fault system through a system of surcharges established by regulation -- a matter that is considered by the Board in Chapter 6. The issues of the effect of increased accident frequency on future price stability and estimated average prices are discussed in Chapters 7 and 8, respectively. In Chapter 8, the Board concludes that, while the effect of increased accident rates on average prices cannot be quantified, the projected savings under the referred systems, as estimated by the Board, are too optimistic and must be reduced to reflect increased accident frequency.

6. OPERATIONAL ISSUES

A. INTRODUCTION

6.1 Three of the specific questions to which the Board was asked to respond require that the Board consider the features of the market and regulatory environment in which the referred systems might function. Specifically, these operational issues are relevant to the first, third and fourth questions which are:

- the estimation of average prices for policies;
- the administrative barriers that could exist and that could result in significant additional costs on an implementation or on going basis; and,
- the stability of the average prices after implementation.

6.2 It is very difficult to "unbundle" the operational issues in a way that fits the separate and distinct questions. These issues are interdependent, and the relationships are dynamic, not static. An alteration in one can have a ripple effect -- sometimes a tidal wave -- across the marketplace. In some cases, the ripple effect is relatively predictable and understood; in other cases, its characteristics cannot be foreseen on the basis of today's understanding.

6.3 The multitude of pressures to make adjustments to the Ontario automobile insurance system do not date from the announcement about product reform made by the Minister of Financial Institutions on April 17, 1989. Those pressures, whether exerted primarily by insurers or insureds, have been at play since at least 1985. Over the four and one-half year period leading up to the Reference, insurers, insureds and governments alike have made decisions about how to respond to the pressures in the marketplace. Not to state the obvious, these pressures and responses have taken their toll and the condition of the marketplace today is delicate, fragile, and tenuous. The Board will not repeat at any length the indicators of the health of the marketplace, as this analysis is equally available to the Government, but does make the following comments, which it considers illustrative:

- the dual nature of automobile insurance, both a product and a service, which must be priced prospectively but which must utilize a broad range of products and services over which it has a limited degree of economic dominance;
- damaging price competition deliberatly engaged in by some insurers which exceeded, to their knowledge, healthy boundaries for this fragmented industry;
- a high degree of confusion among consumers about what contributes to the cost of automobile insurance, how their premiums are calculated and how to use the marketplace to find a better deal;
- rate inadequacy, with its concomitant effects on underwriting selectivity and market capacity;

- a regulatory system focused on reform of the regulatory infrastructure and lacking an appropriate degree of responsiveness to the individual consumer; and,
- a strongly held conviction among many consumers that automobile insurance is very profitable and that premiums are too high.

The Board is not interested in attempting to apportion responsibility for these conditions as there are already many engaged in that discussion. In the Board's view, based on the evidence it heard, it is simply not a reasonable assumption that product reform alone will restore the marketplace to a healthy state. The Board does not doubt that product reform is possible to achieve, but product reform cannot stand alone. It will take a commitment to a tough and thorough analysis of the interrelated features of the marketplace, and it will take significant calibrations made over a number of years as opposed to a single significant one time reform. In the end, it is the Board's view, based on all the evidence it has heard over the last 10 months, that over time, cost is a function of the operation of the marketplace and the regulatory system which governs the marketplace almost to the same degree that it is a function of a type of product.

6.4 What the American experience says to us in Ontario is critical. The Board believes, looking as it did in some depth at the states of New York, Michigan and New Jersey, that one cannot conclude that the relatively successful jurisdictions -- New York and Michigan -- can attribute their success to product reform alone. The reverse equally holds true for the troubled situation in New Jersey. When the American witnesses referred to no fault insurance, they were referring not only to the product but also to the entire regulatory framework in which the product operates.

B. THE KEY: DETERMINING WHAT IS ESSENTIAL

6.5 A road map for this Chapter may be helpful. To understand the context in which the questions must be considered, it is necessary to commence with an overview of the significant factors which govern the relationship between insurer and insured. These are:

- rate regulation
- rating implications of no fault benefits and coverage options
- regulation of classifications, rating methodology and differentials
- surcharges
- consumer information and services

The purpose of this overview is to provide to the Government the evidence from this Hearing about what adjuncts to product reform are possible, and in some other jurisdictions considered essential.

6.6 The characteristics of the referred systems are limited to certain important coverages which would form the core of the contractual relationship between insured and insurer; specifically, the Reference focuses on what monetary protection from losses arising from bodily injury the insured will purchase from the insurer and at what average price. Increasingly, however, governments in many jurisdictions (including Ontario) have regulated other aspects of this relationship in addition to the standard form of contract.

6.7 It is well beyond the scope of the Reference, and the evidence available to the Board, to consider the economic, political and philosophical questions about the degree to which government should intervene in the automobile insurance marketplace. On a practical level, the Board notes that the jurisdictions familiar to the Board in which automobile insurance is delivered by the private sector regulate, in some way, the major areas where the interests of insureds and insurers often conflict. Although these jurisdictions are reasonably consistent in the types of matters regulated, there is considerable variation in the approaches to regulation.

6.8 This overview will be followed by consideration of the specific operational questions relating to each of the referred systems. Following a review of the implementation possibilities, the Chapter will conclude with summary comments relating the principal matters discussed in the Chapter to the second specific question cited above relating to adiministrative barriers. The other two questions are discussed in Chapters 7 and 8, which chapters draw on this Chapter.

C. RATE LEVELS IN ONTARIO TODAY

6.9 One of the most important variables in understanding the operation of an insurance system is the degree to which rates for a product are adequate. As competition generally has a moderating influence on rates, the usual problem is inadequate rates, as opposed to excessive rates. The possibility of both, however, must be kept in mind.

6.10 Ontario private passenger automobile rate levels today are a product of the past and some comment must be made about the following:

- levels prior to April 23, 1987 and up to June 1, 1989;
- levels ordered by the Board in Decision I-88-1D for the period up to December 1, 1989; and,
- levels prescribed by the Government pursuant to Bill 10 (An Act to control Automobile Insurance Rates).

6.11 Levels prior to April 23, 1987 and up to June 1, 1989. Private passenger automobile insurance rates had become increasingly inadequate prior to year-end 1985. As a result, rate increases were taken throughout 1986 in order to restore adequacy and these resulted in adverse consumer reaction. Responding to this and other circumstances in the marketplace, the Government of Ontario requested that companies voluntarily freeze their rates as of April 23, 1987. This requirement was subsequently mandated by statute. Subsequent increases in the capped rates of 4.5% were allowed on each of January 1 and August 1, 1988. Companies were differently placed on April 23, 1987: some already had taken sizeable increases, some were taking more modest increases over a longer period of time, some were playing for market share and keeping increases as low as possible. As a result, companies reacted differently to the allowed increase of 9.2 percent, cumulatively compounded. At the time the Board commenced its consideration of industry-wide rates in late 1988, most companies were experiencing rate inadequacy because increases in loss costs were outstripping the capped rates.

6.12 Board-ordered level (up to December 31, 1989). The Board heard evidence, in Part 4 of the Industry-Wide Hearing, from William M. Mercer Limited (actuarial consultants engaged by the Board), that an approximate increase of 35 percent was needed, industry-wide, for the period from March 15, 1989 to March 14, 1990. The Board adjusted this actuarial indication to approximately 17 percent. The adjustments were based on specific concerns about data quality, particularly in relation to the dramatic increase in 1987 accident year pure premiums and the volatility in the claim frequency data. The Board gave more credence than Mercer to the possibility that the data might be anomalous. The Board selected actuarial assumptions which balanced the possibility that it might be anomalous with the possibility that it was not. Although Mr. Finklestein submitted in this Hearing that the Board had found the 1987 data to be anomalous (Transcript, at 7244), the Board considers this to be a misstatement of its approach. In the circumstances, the Board established benchmark rates at 7.6 percent (the annual loss cost trend actuarially consistent with the 17 percent) above the marketplace rates, and established a range of +9 and -20 percent around the benchmark rates.

6.13 Bill 10 level. The Minister of Financial Institutions announced, on April 17, 1989, the intention of the Government not to allow Board-set rates to come into effect but to limit the allowed increase, for the time being, to 7.6 percent above the marketplace rates. Bill 10 is intended to accomplish that end. It should be noted, therefore, that since April 23, 1987 up to year end 1989, the increases which insurers have had available have been limited to the two 4.5 and the 7.6 percent increases, or approximately 16.5 percent compounded. In this same period, loss costs will have increased about 30 percent.

- Submission of Board Counsel, paragraphs 8.54, 8.55

6.14 There was some dispute as to the relationship between the Board benchmark rates, and today's street rates based on the 7.6 percent cap imposed by the Minister on April 17, 1989. The Board agrees with the argument of Counsel for the Industry Coalition that it is reasonable to assume that the "street rates" are close to the level of the Board benchmark rates. Today's average price is estimated by Wyatt at $475 for the TPL and AB coverages including SEF 44, and $338 for the collision and comprehensive coverages. The average premium is approximately $759 because not all drivers purchase collision (80%) and comprehensive (96%) coverages while all drivers must purchase TPL and AB coverages.

- Finklestein, Transcript, at 7243
- Exhibit 21.2.2, at 11-15

6.15 Wyatt, on behalf of the Industry Coalition, also priced today's product at what Mr. Miller posited was an adequate level. Mr. Miller was of the view that it is appropriate to use the Mercer proposal as a base for the calculation because recently he has had a preliminary review of the 1988 loss data collected by the IBC (data not available to the Board when it set rates in February of this year) and concluded that it supports full inclusion of the 1987 data. He believed that the Mercer proposal was a fair representation of adequate premiums based on a 12.5 percent rate of return during the time period in question.

- Miller, Transcript, at 7044-45

6.16 Mr. Miller, however, made adjustments to Mercer to suit the context of this Hearing. The major adjustment was changing the time frame to the rating period under consideration for this Hearing. The Mercer proposal was intended for the period March 15, 1989 to March 14, 1990. The time period in this Hearing was for rates at June 1, 1989. Mr. Miller also made what he described as minor adjustments to Mercer to allow consideration of "more obscure deductibles and physical damage and some slight adjustment to exposure".

- Miller, Transcript, at 7044

6.17 In Mr. Miller's view, if today's product were priced at an adequate level for 1989, the average benchmark premium for average weighted coverages would be $943, an increase of approximately 24 percent. It should be noted, however, that this average benchmark premium has not been trended through 1990 and, if it were, the percentage increase definitely would be higher.

6.18 Several companies at this Hearing testified as to rate inadequacy for 1989. Without taking into account the 7.6 percent increase in capped rates contemplated by Bill 10, the levels of inadequacy were stated to be as follows:

Allstate: 29.2 percent (Transcript, at 2211)
Dominion: 28 percent (Transcript, at 4250)
Royal: 26.2 percent (Transcript, at 2661)
Progressive: 25-30 percent (Transcript, at 4192)

The farm mutuals generally will be at adequacy provided the Bill 10 increase is maintained.

- Bailey, Transcript, at 3861

6.19 The Board stated in Decision I-88-1D (at 198):

> The Board acknowledges that the rates and upward range established by this Decision may be insufficient for some companies to achieve actuarial adequacy in 1989 ... to the extent that the rates and range established by the Board in this Decision may be insufficient to permit adequacy to be achieved on an industry-wide basis, the next rate proposal to be considered by the Board will likely reflect that fact.

The Board anticipated that the 1988 loss data might confirm the 1987 results, in which case the permitted increase of 17 percent (replaced by Bill 10 and the 7.6 percent cap) would have been inadequate by some measure. The Board has not had the opportunity to review the 1988 data, but assumes that Mr. Miller would be at pains to be correct in his evidence on this important point.

6.20 Although the Board cannot be definitive on the inadequacy in private passenger automobile rates in today's circumstances, the Board is of the view that it could well be in excess of 25 percent, industry-wide for the aggregate of all coverages, for the period from June 1, to December 31, 1989. It should also be noted that the level of inadequacy varies from coverage to coverage.

6.21 The evidence consistently has been that the increase in loss costs is being driven by increases in bodily injury costs, and that it is the third party liability and accident benefits coverages that have the inadequate premiums today. The coverages for collision and comprehensive are typically priced at adequate levels. Across the board increases have been applied to all coverages, evenly. The allowed increases exceeded the loss cost trends for the collision and comprehensive coverages but have been significantly less than required for TPL and AB coverages.

D. RATE REGULATION

1. General Models

6.22 Leaving aside the provisions of the Act which are based on an industry-wide rate setting model, most jurisdictions draw upon three broad categories of rate regulation: prior approval; file and use; and, open market competition. These are described in some detail in an opinion prepared by Professor David Quirin and included in the Osborne Inquiry Report. The Board does not suggest, through this reference, that it agrees with all of Professor Quirin's conclusions, merely that for present purposes the summary is useful. Each of these forms of regulation is applied on a company by company basis.

- Exhibit 13.6.2, at 282

6.23 Each of the American jurisdictions studied by the Board in this Hearing utilizes a form of rate regulation which can be described using the above-noted terminology.

2. Selected American Jurisdictions

6.24 In Michigan (from which Option 1 is drawn), the model is a hybrid of the market competition and file and use models. Prior to 1981, although the legislation incorporated options, generally rates were decided by way of a hearing. Currently, companies are required to file rates and the rates can be used without formal approval of the regulator. Rates, however, can be disapproved by the regulator, subject to a hearing, on statutorily defined bases as stated by Ms. Creamer, Director of Research and Analysis at the Insurance Bureau:

> The test ... is that rates may not be excessive, inadequate or unfairly discriminatory. In order to be inadequate they have to basically endanger the solvency of the insurer as a general rule. In order to be excessive, we have to prove that there is lack of competition in the market. So the primary test that we use is the unfairly

> discriminatory tests. And we have taken action against insurers for having unfairly discriminatory rates, but it is not an everyday occurrence.

- Creamer, Transcript, at 1280, 1294, 1380
- Smith, Transcript, at 2773

6.25 In New York (from which Option 2 is drawn), a prior approval model is used, combined with an excess profits law. This system was introduced at the same time as the no fault threshold (the original dual monetary/verbal threshold came into effect in 1974) and was preceded by a file and use model. Mr. Reiersen, a Chief Insurance Examiner at the Insurance Department, explained that because the State of New York was one of the first to implement no fault, there was some uncertainty about what would happen to rates (up and down), with the result that the prior approval model was adopted as one of "the defense mechanisms" against unpredictability.

- Reiersen, Transcript, at 739, 811-12

6.26 In New Jersey, a new method of rate regulation was adopted at the same time as implementation of the new no fault system on January 1, 1989. Using a flexible or flex rating model, insurers will be allowed to change rates each July 1 within a band. By law, the maximum average rate increase will reflect changes in certain components of the Consumer Price Index plus 3 percent unless this would produce excessive rates, in which case the Commissioner may prescribe the allowable increase. Companies may utilize rates outside the band only on a prior approval basis.

- Merin, Transcript, at 3544-45

6.27 The model of rate regulation used by these jurisdictions tells only part of the story about the relationship between rate regulation and no fault insurance. There are two additional aspects: the effect on rates at implementation, and the actions of the regulators in subsequent years.

6.28 In Michigan, according to Mr. Smith of Ernst & Whinney, who was a senior official at the Insurance Bureau at the relevant time, it was concluded that rates for the new product should not be adjusted downward because the amounts being saved through the operation of the verbal threshold were roughly equivalent to the additional cost of the no fault benefits being added. Rates effectively were frozen for a year or two, then allowed to move up. In the late 1970's, significant rate levels were being reached because of inflationary conditions in the United States, and the evidence suggests that this required the application of significant regulatory resources given the number of hearings resulting from the rate regulation system then in place. Ernst & Whinney suggested that the turnaround time for approval of a pre-1981 private passenger automobile rate application was six months.

- Smith, Transcript, at 2772-75; Exhibit 21.3, at Exhibit 7

6.29 Although the evidence is not precise on this point, it would appear that the inflationary pressures on rates, coupled with the delay in obtaining increases, affected market conduct by insurers (for instance, insurers becoming more selective in risks accepted). As a result, Michigan responded with the Essential Insurance Act (Exhibit 6.17). It set out underwriting rules which govern the circumstances in which an insurer can refuse to accept a risk (Transcript, at 1281). The hybrid file and use/open competition model of rate regulation was adopted at this time which reversed the role of regulator from that of approver of all or most rates to disapprover of some.

6.30 New York followed a different course. On implementation of its first threshold in 1974 -- one that combined monetary and verbal standards -- the State Legislature mandated that rates for the product should be reduced by 16 percent. Mr. Reiersen observed that this was essential to the "selling" of the restriction on lawsuits. He stated that this rate reduction was "unwarranted ... because really ... there was nothing to show that it was going to save 16 percent, and that caused some problems for some carriers". It should be noted that the New York approach was a true "rollback" in that insureds received a credit for the reduction in the cost of insurance between the effective date and the next renewal. Ernst & Whinney disagreed with Mr. Reiersen's statement about the rate rollback and stated that the rates were adequate for the new product, taking into account the rollback. Mr. Reiersen did not comment on the regulator's posture during the period between 1974 and 1977 when the threshold became a strictly verbal one. He stated, with respect to the post-1977 period:

> No matter what rate regulatory scheme you have, if you are doing -- if you are performing properly, and I believe regulators should, whether it is prior approval or file and use, should give a rate based on the experience and that is what we have done in New York, the last ten years at least. Whatever the indications are, based on the experience, that is the rate they get ...
>
> If carriers -- if the experience showed, let's say ... the experience went sour, we would give an appropriate rate increase. The Governor might stop us if it was too high.

Ernst & Whinney suggested that 12 months are required for approval of a rate application for private passenger automobile.

- Reiersen, Transcript, at 646, 809-10, 812-13
- Bryan, Transcript, at 3007; Exhibit 21.3, at Exhibit 7

6.31 New Jersey's orginal no fault law took effect January 1, 1973 based on a monetary threshold. A 15 percent reduction in rates for new and renewal business after the effective date was mandated at that time. In the opinion of Ernst & Whinney witnesses, rates were inadequate before the reduction, with the result that the reduction exacerbated the problem. In this decade, the State has altered its coverages twice. The first changes, which took effect July 1, 1984, allowed consumers to select certain options to the basic coverages which would result in lower premiums (for a description, see Exhibit 8.10, response to Question 9).

6.32 In 1984, these options were priced recognizing their somewhat lower costs, and therefore the reduction for the options selected on renewal were moderate; Mr. Merin (Commissioner of the Department of Insurance) described these reductions as "insignificant". It would appear, however, that rates were inadequate before July 1, 1984 and they have remained inadequate thereafter. Mr. Merin suggested that, for many people, rates did not go up more

more than 10 percent over the next four to five years. Mr. Rossi (President, Independent Insurance Agents of New Jersey) suggested that rates were held down by the regulator during that period for political reasons. Ernst & Whinney concluded that the approval process, prior to the change on January 1, 1989, took 12 to 24 months.

- Merin, Transcript, at 3388, 3403
- Rossi, Transcript, at 3669-70
- Exhibit 21.3, at Exhibit 7

6.33 With the implementation in New Jersey of the new choice format on January 1, 1989, rates for the verbal threshold option were to be reduced by a range of 43 to 67 percent, depending on territory and class differences. Again, these reductions apply to new and renewal business.

6.34 Rate regulation in New Jersey, and its results, have been the subject of much commentary. Mr. David Grubb (Special Deputy Commissioner, New Jersey Department of Insurance) stated in a paper released on April 10, 1989 entitled "Solving the Auto Insurance Crisis in New Jersey" (Exhibit 8.18, at Ex -3):

> Since 1973, New Jersey has used tight controls on auto rates to avoid paying the actual cost of the state's high accident rate and unbalanced no-fault system. As a result, the voluntary market has been unprofitable, and

> the residual market (i.e., the JUA) has grown to almost half of the state's motorists.

3. Ontario Insurers' Position

6.35 Mr. Finklestein stated in argument (Transcript, at 7267):

> In so far as the industry coalition is aware, virtually no segment of the industry - and I may be contradicted by some of the non-standards who may give argument today ... virtually no segment of the industry wants to return to unregulated rating. They all want a form of rate regulation.

The Board would not have drawn the conclusion that there was consensus among Ontario insurers regarding the need for a form of rate regulation from the testimony of the companies which appeared in this Hearing. (See Transcript: Allstate, at 2257-58; Dominion, at 4348-52; and State Farm, at 5543-44.)

4. Commentary

(a) Importance of Attitude to Cost

6.36 It would appear to the Board that rate regulation was well-entrenched throughout the United States before the rise of compensation based on no fault principles. It would be fair to say, however, that states which implemented some form of no fault insurance were not prepared to conclude that it rendered rate regulation redundant. In fact, it is likely that the greater the degree of uncertainty about prices in no fault, the more attractive rate regulation becomes, to the regulator and, in some circumstances, to the regulated.

6.37 It can be seen from the three states considered that there is no necessary correlation between compensation based on no fault principles and any particular form of rate regulation. The Board agrees with the Ernst & Whinney witnesses that a critical factor is the matter of the publicly stated reason(s) for the introduction of no fault, because this likely determines the effect of rate regulation on rates, on implementation and in the future (Bryan, Transcript, at 2777-78):

> ... in the United States it's important when the no-fault issue was discussed, that there be a clear concept of what it is that the no-fault approach is supposed to accomplish. In the United States there has been confusion on this point ... And the confusion arises because two paths have been taken. One path says that the purpose of implementing no-fault is to improve the efficiency of the system so that more benefits can be paid to people that are injured in order to compensate them for their loss, to help them be rehabilitated and so on. And the overall price is not something that is being -- that is not the most

> important issue ...
>
> The other track that has been taken is that the purpose of implementing no-fault is primarily to reduce the price level and therefore whether it's successful or not will be judged by whether or not the price level is reduced ...
>
> Some jurisdictions such as New Jersey, in our judgement, there was significant confusion on this point, and that led to major problems later on.

6.38 A comparison of the experience of Michigan, New York and New Jersey is instructive on this point. Michigan is perhaps the best example of a state that moved to no fault in order to improve benefits, not to reduce costs. Even in the face of relatively stiff increases in costs on an on-going basis, Michigan appears to have allowed rating to proceed by reflecting the real costs. Of particular note is the fact that Michigan moved to a variation of regulation by open market competition at a time of inflationary pressures. Michigan's efforts have been directed much more to ensuring that consumers are fairly treated in the marketplace through regulating classification and underwriting (witness the more frequent use of the "unfairly discriminatory" test in its actions to disapprove rates) and less to using rate regulation to exert downward pressure on rates.

6.39 The Board notes Mr. Reiersen's candour in commenting on the New York experience. Although the 16 percent reduction in rates on implementation might have been somewhat arbitrary (in the sense of lacking actuarial justification), the system has performed sufficiently well that rate increases have been moderate. Mr. Reiersen stated that the New York regulators have a commitment to keeping rates adequate, although to date there has not been any real tension between the rate level required to achieve adequacy and the political acceptability of that level.

6.40 It would be difficult to argue against the proposition that the cost of automobile insurance in New Jersey is central to regulatory action there, including downward pressure on rates over a number of years. The Board is of the view that the situation in New Jersey is sufficiently complex that useful conclusions are difficult to draw. The experience in the State, however, certainly confirms that rate regulation, in and of itself, cannot cure the problems of increasing loss costs. Further the "cure can become worse than the disease" because the marketplace can be frustrated in making any remedial adjustments.

(b) Resource Considerations

6.41 The various forms of regulation differ in the resources required to support the system of rate regulation. Both Michigan and New Jersey have moved to systems which should reduce, to some extent, the pressure which would otherwise be on the regulator in a period where rates are inadequate if prior approval must be given on a company by company basis. This is an important point to be kept in mind in Ontario. If a decision is made to move to such a model, and the rates going into the new system are inadequate by some measure, it is forseeable that a significant "bottleneck" could occur and that bottleneck would undoubtedly have ramifications in the marketplace. Other results could flow from other models. If an open competition model were adopted, with the onus on the regulator to disapprove rates on a company by company basis, it might still be very difficult for the regulator to take quick and necessary action in the interests of consumers in the rush to put in place new rates. While the Board understands the role that competition can play in restraining upward pressure on rates, the transition to a new system will be a time of uncertainty, and it is important that a basic level of consumer confidence be maintained.

(c) Who should have the Burden?

6.42 The Board notes with interest Mr. Finklestein's statements with respect to industry support for rate regulation. The Board assumes that one of the principal reasons for this industry position is that companies appreciate that the fragmented character of the industry can lead to unwarranted price competition which lowers prices, followed by necessary periods of recovery and large price increases. The Board, in this Hearing, saw another side to the industry support for some form of rate regulation. One of the themes in the questions asked of various witnesses on cross-examination by Counsel for the Industry Coalition was to the effect that the regulatory system could be used to solve the particularly hard, and usually contentious, problems which arise in some areas, including the rate level for surcharges. This question of the distribution of decision-making authority as between the regulator and the regulated is an important one for the future health of the system. In the U.S. jurisdictions they appear to have it well in hand although the amount of budget allocated to regulators has recently come under criticism. A joint report of the Consumer Insurance Interest Group and the National Association of Professional Insurance Agents in the U.S. (April 1988)

(Exhibit 4.27.2) recommended that State Governments should adopt as a minimum a ratio of 10% of premium taxes collected to fund the regulator. Based on this measure, for instance, New York was at 11%. On a comparative basis, Ontario presently (combining Superintendent and Board costs) spends around 6%.

E. RATING IMPLICATIONS OF NO FAULT BENEFITS AND COVERAGE OPTIONS

1. Pricing for the Average

6.43 Benefits relating to bodily injury are found in two parts of the current SPF 1: Section A (Third Party Liability) and Section B (Accident Benefits). In determining the premium under Section A, it is impossible to predict the personal characteristics of those third parties who are injured through the fault of the insured. With respect to the tort-based part of the policy, therefore, rates have been set on the basis that the victim is "average" (Hunter, Transcript, at 6783). There was no evidence on the rating of Section B benefits. The current Section B benefits -- for instance, with respect to loss of income payments -- are sufficiently low, however, that any cross subsidization among insureds is minimal and therefore it would be unlikely to be cost-effective, to insureds, to correct it.

2. Utilization of No Fault Benefits

6.44 Both the Section A and B coverages are mandatory, and the referred systems retain that requirement (with the exception of choice no fault where third party liability benefits serve no purpose apart from residual body injury).

6.45 There are significant numbers of insureds who cannot claim fully under the Section B benefits, who must nonetheless pay a premium based on the full benefits. In the first broad category are those who may not meet the eligibility requirements (see Chapter 3).

6.46 In the second broad category are those who are eligible under Section B, but who are also eligible for benefits of a certain type which are primary to the Section B benefits and therefore must be paid out before the Section B benefits (see SPF 1, Section B: Subsection 1 (Medical, Rehabilitation and Funeral Expenses), last paragraph; Subsection 2, Part II (Loss of Income), item (5); and, Specific Provisions, Definitions, and Exclusions of Section B, paragraph (8)).

6.47 The obvious problem for both of these groups is that they are paying, to some extent, for benefits which they can never receive. This statement can be qualified because price competition probably forces insurers to recognize some of these savings or offsets in selecting rates. Costs, however, are imposed on these individuals without adding any value to their protection. Also, these individuals subsidize those who are eligible to claim the benefits. It may be helpful to note how the subsidies may run with respect to loss of income. The higher and lower earners are likely to subsidize the large group in the middle. Many higher income earners will have access to disability benefits which are primary to automobile benefits and low income earners or those not earning income at all will be limited in their claims for loss of income (Exhibit 13.6.1, at 574).

3. Looking at the Referred Systems

6.48 With the enriched no fault benefits incorporated in Options 1 and 2, and in particular the choice no fault portion of Option 3, the proportion of the premium attributable to the no fault benefits is much greater than today. A comparison of the average premiums as calculated by Tillinghast (Exhibit 5.1(b), at Exhibit 1, Sheet 1) and Wyatt (Exhibit 21.2.2, at VI-3VI-7) illustrates both the absolute increase in the cost of Accident Benefits, and the relative size of such benefits compared to the Third Party Liability coverage (which includes a property damage component):

TYPE OF COVERAGE		AVERAGE BENCHMARK PREMIUM	AVERAGE MARKET PREMIUM	THRESHOLD		CHOICE	
				OPTION 1	OPTION 2	TORT	NO FAULT
TPL & SEF 44	T	$ 509		$ 362	$ 393	$ 527	$ 185
	W	$ 507	$ 432	$ 394	$ 422	$ 263	$ 230
Accident Benefits	T	$ 50		$ 136	$ 136	$ 51	$ 141
	W	$ 50	$ 43	$ 166	$ 167	$ 293	$ 148

T = Tillinghast

W = Wyatt

Notes:

1. Average Market was developed by adjusting the "frozen street rates @ 08/08/89" estimated by Wyatt for the 7.6% capped rate increase allowed on rates after June 1, 1989.
2. The Expense Constant has been prorated back into the estimates for the Average Benchmark Premium or the other options based on the coverage premium as a percentage of total average premium.
3. The Average Benchmark Premiums are higher than the Average Market Premiums for these coverages. However, this is offset somewhat by higher Average Market Premiums for other coverages that would normally be purchased by the insured.
4. The Tillinghast estimates have been changed for the reduction in savings as a result of some changes in underlying assumptions. These changes were given by Tillinghast on an all coverage basis only (Transcript, at 7106-09). The all coverage change was allocated between Liability and Accident Benefits based on the source of the change and amount as given by Tillinghast.

- Wyatt Report, Exhibit 21.2.2, at II-15, V-4, V-5, V-6, V-7.
- Tillinghast Report, Exhibit 1, Sheet 1 of Exhibit 5.1(b), as modified by Transcipt, at 7106-09.

6.49 The Ontario Mutual Insurance Association (Exhibit 21.7, at 3-4) argued that its members might be particularly disadvantaged given these rates because of another aspect of the rules about which benefits are primary:

> The impact of a no-fault system of automobile insurance will be felt much differently by a rural insurer than an insurer who predominately underwrites urban policyholders.
>
> While we do not have hard statistics, it is commonly known that an urban driver is much more likely to have a wage continuation plan through his employer than is a self-employed farmer. Since the disability income benefit will be off-set by other types of disability insurance and salary continuation plans, an insurer who predominately insures farmers will not realize this benefit to the extent that the urban underwriter will.

6.50 The average estimated prices calculated by Tillinghast and Wyatt incorporate an estimation of the costs which will be saved in the specified cases where the automobile insurance coverages are not primary. The characteristics of the books of business of insurers, however, may vary widely and may not mirror any assumption which is reasonable looking province-wide. If companies are in some way tied to rates estimated on a province-wide basis, their costs may be understated (as would be the case for the farm mutuals in the circumstances described above) or overstated. Allowing a range of rates, or company specific deviation applications, would assist in addressing these problems.

6.51 It should be noted that, as required by the first question in the Reference, these average prices are based on Class Plan Orders No. 1 and 2 issued February 1 and March 16, 1989, respectively and the two Rate Orders issued, respectively, on February 13 and March 16, 1989, all pertaining to private passenger automobiles. The rating algorithm for the Accident Benefits portion of the premium (Rate Order No. 2, Appendix B) provides that only the following components are to be used:

Territory base rate

Classification variables: vehicle use
annual driving distance
years licensed
abstinence
low risk driver

Surcharges: conviction history
vehicle claim history

4. Remedial Approaches to Cross Subsidization and Duplicate Benefits

6.52 One type of remedial approach to cross subsidization discussed at the Hearing was the use of classification variables which are more similar to those used in pricing life or accident and sickness coverages (Rogacki, Transcript, at 4137). A variation of this type of approach is to apply a discount factor to a rate on some basis (Kelaher, Transcript, at 2253-54; Hunter, 6859-60). Two other measures are based on a retreat from the strict mandatory approach. The first would allow insureds to buy down certain of the sub-coverages within Accident Benefits in circumstances where they could not otherwise make a claim because they did not meet the conditions of eligibility (Kelaher, Transcript, at 2132); the second, through a method known as coordination of benefits, would allow insureds to designate other benefits plans as primary.

6.53 The subject is peripheral to the questions in the Reference (which focus on average premiums). Further, these issues were not pursued in any real depth by the parties, with the result that there is limited evidence and limited understanding of their positions. In the view of the Board, however, it may be helpful to provide some background information on each possible remedial measure.

(a) Possible Classification Variables

6.54 Messrs Oakden and Trudeau of Tillinghast, primarily in response to cross-examination conducted on behalf of FAIR, suggested or agreed that the following variables might be appropriate for the insured and covered family members (Transcript, at 485-90, 529-31):

- family size
- age of family members
- occupation
- salary
- health
- life expectancy
- anticipated recovery from other plans

(See also Transcript, at 4066-67 for evidence of Progressive; at 4590-91 for evidence of Kingsway; and, at 6781-83 and 6854 for evidence of Mr. Hunter.) Mr. Hunter commented in his pre-filed evidence (Exhibit 30.2, at 8):

> If you move to no-fault, salutary classification changes are possible ... Under no-fault, the premium can fit the insured's known factors, such as wage and age (lower cost for lower paid, better healing capacity of the young). While frequency of accident within class will still tend to dominate final differential prices, lower

income and young (today's most unaffordable classes) will get a break.

(b) Discounting

6.55 The State of New York gives a reduction in premium to senior citizens who cannot claim lost wage benefits. It is in the range of 10 to 15 percent (Reiersen, Transcript, at 734-36). In Michigan, insureds with low income or those who have reached retirement age are given credits, presumably to reflect the lower wage loss claims for these groups (M.C.L.A. 500.3109; Smith, Transcript, at 3020).

(c) Buying Down or Opting Out of Mandatory Coverages

6.56 At several points in the Hearing, questions were posed which were intended to test the efficiency or wisdom of retaining mandatory limits in Ontario. This is a large, and potentially controversial, subject. The Board notes that the evidence from several American states indicated that the pressures to keep automobile insurance rates affordable have operated to keep third party mandatory limits at about $50,000 (compared to $200,000 in Ontario). That issue is not discussed in this Report. Rather, what is meant is the limited situation where an insured cannot make a claim under a mandatory coverage and therefore cannot receive any benefits for his or her expenditure on premium. It would appear from the evidence, however, that this type of measure has not been introduced in any jurisdiction considered in this Hearing.

(d) Coordination of Benefit Plans

6.57 There are two aspects to coordination of benefits. The starting point is a decision as to whether the medical and/or loss of income benefits are to be paid without regard to similar benefits available to the claimant under public or other private plans. The issue is whether the automobile benefits will be "primary". If it is mandated by legislation that certain benefits under the contract of automobile insurance will not be primary, but will be paid, up to the maximum, as a "top up" to other benefits, a form of coordination exists. If, however, the automobile insurance benefits are to be primary, then from the consumer perspective coordination of benefits may be attractive because similar benefits may be available to the insured for less cost than the premiums relating to the particular automobile insurance coverage.

6.58 Coordination of benefits may reduce the total cost of automobile insurance (by shifting costs outside of the automobile system), as well as the automobile insurance premiums charged to any particular individual who has benefits to coordinate. It fundamentally is an exercise in shifting costs. There is a significant and timely public policy question as to whether the cost of automobile accidents should be borne totally within the automobile reparations system and therefore by those who participate in driving. Mr. Hunter argued that consumers would gain the most advantage if the most efficient systems were primary. In a case of loss of income benefits, he would not be troubled by a shifting of those costs to accident and health or disability income insurers because, in his view, those types of insurers deliver that type of product most efficiently.

- Hunter, Transcript, at 6827

6.59 Considering the referred systems, coordination of benefits is not an issue with respect to disability income benefits because, with the exception of unemployment insurance, the benefits to be provided are not primary. The remaining question therefore, is the degree to which coordination of benefits is possible, and to what extent cost effective, under the other coverages. The Board notes that the Reference does not indicate whether the medical/rehabilitation benefits in the referred systems would be subject to a provision similar to that contained in SPF 1, that is, that insurers are not liable for "expenses payable or recoverable under any medical, surgical, dental or hospitilization plan or law". Board Counsel relied on an assumption that medical/rehabilitation expenses would be excess to OHIP under the referred systems (Exhibit 5.3.2, item 17). To the extent this assumption is not correct, the Board's costings and comments on future price stability would be different as medical/rehabilitation expenditures will increase significantly.

6.60 Some examples of the magnitude of the possible reduction in no fault premiums can be gleaned from several states. In New York, coordination of benefits is limited to disability income benefits, where insureds are members of experienced-rated private plans which would otherwise result in a double recovery of benefits. Michigan makes use of coordination of benefits. PIP coverage is compulsory but it may be purchased subject to both deductibles and exclusions "reasonably related to other health and accident coverage on the insured" (M.C.L.A. 500.3109(a)). If an insured decides to make another plan primary, the insured receives a discount of, on average, 10 percent. Otherwise, the insured pays the full PIP premium and is entitled to "double dip".

- Reiersen, Transcript, at 734-36
- Creamer, Transcript, at 1272-73, 1373; Gromek, 1438-39; Exhibit 6.8

6.61 New Jersey recently has taken a somewhat different approach to coordination of benefits. Until December 31, 1988, no fault benefits were primary in New Jersey. As of January 1, 1988, changes were made to PIP benefits (P.L. 1988, c. 119). The purchase of PIP - medical expense benefits is mandatory in New Jersey. There is a deductible for this coverage ($250 minimum per accident, section 3), as well as a 20 percent co-payment by the insured on a sliding scale up to $5,000 (the policy will pay 80 percent of medical expenses from $251 - $5,000, and 100 percent thereafter, section 38). Private health insurance policies may cover these deductible and co-payment out-of-pocket expenses depending on the specific policy provision (Baker, Transcript, at 6689). It has been estimated that the deductible and co-payment changes will result in a premium reduction of approximately $25 (Exhibit 8.17, at 4). The other types of PIP benefits are optional and coordination is allowed (Exhibit 8.9; Merin, Transcript, at 3429).

5. Benefit Options

6.62 Each of the benefit levels included in the no fault benefit portions of Options 1, 2 and choice no fault of Option 3 are subject to a maximum level or a form of capping. It will be clear from Chapter 3 that the verbal thresholds can exclude injuries which many, as a practical matter, would consider to be serious. So long as recovery in tort is available for excess economic losses, an individual who is not at fault, for whom the level of no fault benefits is inadequate, has a remedy for his or her loss available. In the case of choice no fault, no such remedy is available.

6.63 It must be determined whether it would be in the interest of consumers to allow them to purchase benefit levels in excess of those available in the referred systems. It may be that, for Options 1 and 2, it would be cost effective to do so given that it might function as another disincentive to legal action. In the case of choice no fault, it may well be the only way for individuals to purchase adequate coverage for their needs. The Board is particularly concerned about the adequacy of the basic disability income benefit, as reviewed in Chapter 3.

6.64 Mr. Hunter was very much in favour of the availability of additional benefits at the option of the insured (Exhibit 30.2, at 7):

> Make no mistake about it. What we are considering with no-fault is lowering the legal rights of the people of the Province, even under the so-called Choice Plan since full disclosure of all possible outcomes, costs and benefits of Choice are impossible. This must be undertaken in a most serious and delicate way ...
>
> Even with its faults, the tort system does offer benefits that tend to 'fit' the injured party's injury. You must consider if offering some system of tailored benefits (through building blocks of guaranteed additional coverage options) can be flexible enough for Ontario's motorists who suffer a claim.

Two examples were given of the type of benefit options which deserved consideration: excess wage loss and inflation protection above the capped amount for younger employees.

- Hunter, Transcript, at 6781-84

6. Revision of Benefit Levels

6.65 As noted in paragraph 3.5, the dollar levels of the current Ontario add-on no fault benefits have not increased since 1978. Inflation has seriously eroded the real value of those benefits. In fact, Professor

Carr stated that the current $140/week wage loss replacement benefit, adjusted for inflation, should be about $300/week today (Transcript, at 5984). Some form of periodic revision of the base no fault benefits is likely to be required. It may be decided that such a revision must be done by legislative enactment, depending on the format of the implementation legislation and the SPF. Alternatively, the legislation with respect to the contractual benefit levels could provide an automatic formula for updating the base benefit levels. For instance, in Michigan, the maximum monthly benefits for wage loss and survivor benefits are required, by statute, to be indexed annually based on the Consumer Price Index (Creamer, Transcript, at 1376). Keeping benefit levels reasonably current is, depending upon economic conditions, a significant additional on-going cost.

6.66 Professor Carr, in response to questions from Messrs O'Donnell and Beatty, recommended a full indexing of accident benefits. That is, Professor Carr believes that the base level of benefits should be indexed to inflation, as should the stream of payments. Benefit levels should be maintained in real terms.

- Carr, Transcript, at 5984-86, 6037

7. Commentary

6.67 To a great extent, these issues highlight what may be competing interests for consumers. On the one hand, consumers are likely to prefer an insurance product which allows them to create a personalized package, or to balance their most important coverage and benefit level needs with their financial circumstances. On the other hand, a system with a reasonable number of options, of necessity, may have characteristics which can function to frustrate consumers. The first characteristic is that consumers will be faced with more choices to make than today. The second is that it will affect costs in three ways. First, it may be more costly to administer. Secondly, it may result in an increase in province-wide costs and may mask any cost reductions which occur at that level achieved through product reform. Thirdly, it would be a significant factor in determining how an individual's premium compared to the average premium, thereby creating a source of frustration for the individual insured who had an expectation of savings based on average premiums.

6.68 Consumers are reasonably accustomed to making choices with respect to property damage coverages and limits. Choices with respect to bodily injury coverages and benefit levels would be new apart, of course, from the existing requirement to select a third party liability limit.

6.69 The Board heard a number of opinions on how consumers were reacting to the choice system put in place in New Jersey effective January 1, 1989. The principal items pertaining to bodily injury coverages which require choices in New Jersey are (Exhibit 8.9, Coverage Selection Form):

- New York-style lawsuit threshold or no threshold
- PIP coverages
- PIP deductible pertaining to medical expenses
- uninsured/underinsured coverage limits

Mr. Merin commented (Transcript, at 3387):

> [Q] What kind of reaction did you get concerning the choices that were being offered to consumers?
>
> [A] Confusion. Most consumers find paying for insurance a difficult enough situation without having to be forced to spend time concentrating on the various options.
>
> Most consumers, when I speak with them, seem to want to have lower cost policies but they don't want to have to wade through stacks of material, very complex materials, to try to understand the options and try to link those options up with their own coverage in other areas.

Mr. Rossi, an independent agent, stated that there are several hundr d combinations of options from which an insured, base on the government-prescribed Coverage Selection For can select (Transcript, at 3585). Mr. Dolin, anothe independent agent, indicated that these types of opti s also are complicated for the sellers of insurance to ster (Transcript, at 3573).

6.70 In cross-exa ning the witnesses from New Jersey, Counsel for t Industry Coalition separated the choice with respect o the verbal threshold or no threshold from the othe types of choices. This was a defensive reaction to a erious criticism of a system which allows a choice in l ability rules. In Argument, Counsel for the Industry alition dismissed this criticism with the following sta ement (at 18):

> If one's mindset is that a choice cannot be explaine to citizens, that mindset determines the resu . If on the other hand, one makes a seriou and constructive effort to have the experts n the issue and experts in public communic ions sit down and determine to place the issu squarely and fairly to the public, then tha result will be achieved.

6.71 The Board i not so willing as Industry Coalition Counsel to be eve that success will be guaranteed. The Board is o the view that it is fundamentally contradictory to take the position that the choice option can be put forward in an understandable way, and yet that other coverage and benefit options cannot.

6.72 In the Board's view, the timing allowed for implementation of any product change is critical to any form of public education. In New Jersey, the changes became law in November with an implementation date of January 1 following. This did not allow enough time for insurers to produce and forward the prescribed forms and information, let alone allow sufficient time for meaningful education of agents and insureds by a variety of means.

6.73 The Board is of the view that it is advisable for a consumer to be able to personalize his or her coverages and benefits to the greatest degree possible. It will remembered that a number of these options will contribute to lowering insurance premiums for individuals, albeit modestly. Either the matter is important enough to put consumers in a reasonable position to do it on an informed basis, or it will be a constant source of confusion, tension and criticism in the system. Proper consumer information and education should enable better choices and thus put on pressure to increase the efficiency of the total system.

6.74 The Board does not have before it sufficient evidence to make definitive comment on the administrative costs of implementation. One type of cost has already been mentioned, i.e., agent or broker education and public education. There may be other types of transaction or delivery costs which will increase. For instance, if the classification scheme is altered to add the types of classification variables listed in paragraph 6.53, there may be pressure to increase broker commissions and there may be a need for information verification resulting in increased administration costs. An increase in broker commissions would be significant, while the other additional costs might be minimal.

6.75 The average estimated costs which are reviewed in Chapter 8 do not incorporate the costs which would flow from optional coverages or benefit levels in excess of those included in the referred system. In particular, they do not include the costs of upgrading the base benefits to keep level with the rate of inflation, or that of fully indexing the benefits paid over time. They would increase costs system-wide, although these costs should be distributed through classification to those who should properly bear them.

6.76 The third cost implication -- that some individuals might not actually benefit from a reduction in average estimated costs -- will be a problem whether coverage and benefit level options are allowed or prohibited. It is related to how classification differentials spread the premium amongst individuals.

F. REGULATION OF CLASSIFICATIONS, RATING METHODOLOGY AND DIFFERENTIALS

1. Rate Regulation and Uniformity

6.77 The Reference directed, in the first question, that the average prices for the referred systems be based "on the mandatory classification system, the determinations of fact and rates established by the Ontario Automobile Insurance Board under its decision of February 13, 1989." As a result, the average estimated prices are based on the class of risk exposure and the rating algorithms for each coverage which are uniform for each insured person in Ontario, and uniform differentials which can vary only insofar as the resulting rates are within the Board-set range of rates.

6.78 Throughout its decisions in the various parts of the Industry-Wide Hearing, these uniform building blocks were required under the Act. Clearly, the issues of rate regulation, and classification, rating methodology and differentials, are linked. If rates are to be either set or monitored on some industry-wide basis, the Board is of the view that uniformity in classification, rating methodology and differentials is essential given the reliance that would be placed on industry-wide statistics in such a regulatory scheme. If, however, rates are to be set on a company by company basis subject to some over-riding approval or disapproval power, uniformity is not essential for purposes of rate regulation, although the regulatory authority will have to develop approaches which allow insureds of different companies to satisfy themselves that there is equity in the regulatory process.

2. Consumer Interests

6.79 It is beyond the scope of this Report to consider what consumer interests are relevant to classification, methodology and differentials. The Board notes that a full analysis might well identify areas of tension between the interests of consumers as a whole and the interests of individual consumers. One interest of consumers, however, stands out from the evidence in the Industry-Wide Hearing and in this Hearing, that is, the importance of good price information.

6.80 An obvious question is what constitutes "good" price information. In the Board's view, it is possible to identify at least two critical features of good price information. The first is that the consumer must be able to understand the basis on which the price he or she is to be charged is calculated. The second interest is that the consumer be able to make meaningful comparisons among the prices to be charged for a similar product by competing insurers. Although understandability is not exclusively a function of uniformity, a degree of uniformity certainly will affect the nature and usefulness of comparative prices. In the Board's view, Mr. Hunter's support for a modified but uniform classification plan is largely based on the importance he attaches to good price information (Transcript, at 6940).

6.81 The Board also notes Mr. Hunter's comment with respect to the importance of a uniform classifcation plan in the particular circumstances of the Province of Ontario if it embarks upon product reform. His view was that information will be critical in the transition period. It will be "very difficult" to inform consumers of all the changes affecting them if the usual marketplace variety of classification plans is in place (Transcript, at 6940).

6.82 It must also be remembered that, as discussed above with respect to the rating implications of no fault benefits, companies in an unregulated marketplace may introduce new classification variables or new forms of discounting on the transition to one of the referred systems. Companies could vary widely in the approaches they take. While insurers might not be expected to have any reasonably common approach to classification at this stage of analysis of the referred systems, the Board was surprised at the apparent lack of attention and thought which had been given to this question by companies other than the non standard insurers.

6.83 Each of New York, Michigan and New Jersey has taken different approaches to the regulation of these matters. In the Board's view, it is not possible, on the evidence in the Hearing to make any useful comment about the reasons behind each approach and its relevance to Ontario.

G. SURCHARGES

6.84 Given the importance of surcharges and the considerable amount of evidence on the subject, in this Hearing, they will be discussed separately.

1. Purpose

(a) Risk and Predictability

6.85 Insurers have levied claims and conviction surcharges in the Province of Ontario for decades. Such surcharges were included as rating variables in Class Plan 406 -- prescribed by the Lieutenant Governor in Council as a regulation under the Act and subsequently amended, with respect to private passenger automobiles, by an Order of the Board issued February 1, 1989, as amended. Therefore, the Government of Ontario considered the public policy purposes of surcharges at the time of the preparation of Class Plan 406.

6.86 The Board Class Plan contains a definition of "chargeable vehicle claim". Amongst other conditions, a claim is not chargeable "if fault is fully attributable to a third party". To the extent that the referred systems rely less on a determination of fault for the payment of benefits, and therefore fault is less determinative of the risk any insured presents, it will be obvious why a significant question arose in this Hearing as to whether claim-related surcharges should be maintained and, if so, with what administrative implications. A particular application of surcharges to reduce possible adverse selection in the choice option will be discussed later in this Chapter. A useful starting point for a response would be an understanding of the purposes underlying surcharges, something which may seem obvious but is decidedly not so on the evidence in this Hearing.

6.87 The common starting-point in the industry is that claim surcharges are intended, like other rating variables, to reflect the risk which an individual insured brings to the pool or, more accurately in today's structure, to his or her insurer. Prior to the Board Class Plan and therefore today still in the marketplace, surcharges apply to third party liability, collision and the collision portion of all perils coverages -- but not to accident benefits. In the case of third party liability coverage, therefore, "the risk" being measured should be the risk of being involved, in the future, in an at fault accident because that is a condition of payment under this coverage. In the case of any collision-related coverage apart from third party liability, "the risk" being measured should be the risk of being involved, in the future, in any accident, at fault or otherwise, because these coverages are paid on a first party basis (the same reasoning would apply to accident benefits).

6.88 Insurers, however, do not surcharge for not at fault accidents resulting in payouts under first party coverages because, when it has been tried in the past, consumers have reacted negatively. Insurers, however, are sensitive to payouts and one of their defenses is to refuse to write a risk with a number of not at fault accidents. Not only is this more likely to happen in today's tight marketplace, but also the risk is unlikely to be written at all in the voluntary market, forcing the individual into the significantly more expensive Facility Association.

6.89 There are many automobile insurance professionals who would maintain that involvement in at fault accidents by an individual is a predictor of future involvement in at fault accidents. Also, some insurer books of business establish this relationship.

6.90 The very limited empirical evidence presented at the Hearing, however, is more problematic and does not itself establish, as a reasonable assumption, that involvement in an at fault accident is an indicator of future involvement in an at fault accident. The actuaries giving testimony at this Hearing appeared to agree that the empirical evidence establishes that involvement in an at fault accident is an indicator of future accident involvement.

6.91 Mr. Oakden was of the view that although "certain individuals might be at fault in a higher proportion of cases ... certain individuals tend to get into a lot more accidents regardless of fault" (Transcript, at 449-50).

6.92 Mr. Miller did not believe "that there exists an identifiable class of drivers who have only at-fault accidents" (Transcript, at 7071). Based on Mr. Miller's analysis of Quebec data (Transcript, at 7072):

> Somebody who has had a number of recent at-fault accidents or even one recent at-fault accident is much more likely to have in the next rating period another at-fault accident than is someone who wasn't like that. But they are also proportionately more likely to have a not at-fault accident in the subsequent rating period.

6.93 Mr. Boulanger, the Assistant Vice-President of Actuarial Services and Corporate Management Information of Allstate Canada, relied on certain Quebec statistics (Exhibit 21.18) which were assembled, presumably by Mr. Boulanger, to ascertain whether any group of insureds has only or mostly at fault claims. Looking at five year averages, ending in 1987, for liability and collision frequencies for urban and rural territories by driving record, he drew the conclusion from this data that involvement in at fault accidents is an indicator of future involvement, both of at fault and not at fault accidents. This data, and Mr. Boulanger's use of it, were subject to extensive criticism in the Argument made on behalf of FAIR (at 16-23).

6.94 While the Board does not adopt the criticisms of FAIR as a whole, the Board cannot place much weight on the Quebec data and conclusions thereon relied upon by Mr. Boulanger. This evidence was not sufficiently presented in direct examination or tested in cross-examination. The Board is particularly concerned that the methodology and reasoning underlying the observed results and conclusions have not been sufficiently explained. At a very basic level, given that the frequency data does not make any distinction, on the face of the document, between at fault and not at fault accidents, the Board does not understand how one component -- at fault accidents -- can be compared to at fault and not at fault accidents combined. If the data includes at fault and not at fault accidents (as the conclusion suggests), Mr. Boulanger did not rely on it to determine the predictive capacity of not at fault accidents, but instead relied on "general reasoning" to conclude that not at fault accidents also are a predictor of future accident involvement, not of accidents of a particular type (Transcript, at 2151). The Board regards the data on which Mr. Boulanger based his evidence as inconclusive.

6.95 As a practical matter the Board queries how many insurers, in pricing their products, rely on the related but somewhat different understanding of the predictive capacity of at fault accidents posited by the actuaries in this Hearing, as opposed to their experience and their unique books of business. The Board is reminded of the evidence it heard in Hearing I-88-1D with respect to how pricing decisions are made at the company level as summarized in paragraph 6.76 of that Decision:

> The evidence of the companies with respect to their pricing process is summarized in the Submission of Board Counsel as follows (at 7/5):
>
> 7.14 Generally the pricing process was described as consultative in nature with input from a number of individuals. The companies agreed that representatives of the actuarial, marketing, underwriting, claims and financial departments provide input to the decision. The ultimate pricing responsibility rests with the CEO of the company.
>
> 7.15 The pricing process outlined did not vary significantly by company. Generally the actuarial department provided an indication of required rates based on past experience. The underwriting and claims departments indicated changes in their books of business or claims

> experience which required a change in rates. A key input to the process was provided by the marketing department. They assessed the market environment and actions of their competitors.

6.96 The Board also recalls the evidence of William M. Mercer Limited (filed as Exhibit 5.1, at 55-56) in Hearing I-88-1D with respect to the quantification of the rating variable based on the number of chargeable claims in the insured's most recent six year history and the number of claim-free years since the last chargeable claim. The claims under consideration, therefore, largely were at fault claims:

> Several studies from other jurisdictions have linked claim history with the probability of future claims. The studies indicate that a driver's claim history is correlated with his/her future claims potential; and the higher the number of prior claims, the greater the chance for future claims. These studies did not provide enough data to form a basis for quantifying this classification variable in conjunction with all the other classification variables, however, since no other risk characteristics were provided.

6.97 Surcharges thus are an imperfect measure of risk propensity for two reasons. The first is that they are over-inclusive or under-inclusive to some degree. The second is that they are difficult to quantify. Nonetheless, the Board notes that a better method of measuring risk for rating purposes does not appear to have been developed and put into use.

(b) Consumer Views

6.98 Evidence before the Board in Hearing I-88-1D indicated that there was strong public sentiment in favour of increasing surcharges for drivers with claims and convictions. A very clear punitive attitude towards these drivers was evident. It also was stressed that only at fault claims should be surcharged.

6.99 Although surcharges are applied in respect of the possibility of future accidents and are not intended as punishment for past actions, that distinction, if understood, is not necessarily accepted by consumers. Also, many consumers do not understand how surcharges are calculated and applied to their ultimate rates. As surcharges can make automobile insurance very expensive for almost any pocketbook, they have been one reason for the high cost of automobile insurance to an individual.

6.100 It is very possible that the continued application of surcharges in a no fault system will come as a surprise to those who must pay them because, intuitively, one would think benefits and rating would be approached on a consistent basis. Many people, however, have no sympathy for those involved in accidents and want the people who are causing costs to the system as a whole to pay for their share of the losses. "Good drivers" see surcharges as a way of preventing rate subsidies for "bad drivers".

6.101 In Michigan, the Ontario equivalent of the property damage portion of third party liability, is paid on a first party basis. By law, the surcharging of not at fault accidents is prohibited. Ms. Creamer indicated that there is a lack of understanding about how the surcharge system works, even after 17 years of operation. People are concerned that they will be penalized when their insurer makes a payment if they are not at fault. Consumers also feel the need for revenge against the at fault driver, and believe that it is unfair that their own insurer should have to pay for the not at fault accident.

- Creamer, Transcript, at 1291-92, 1311

6.102 In Quebec, a new bill is being introduced which would allow a driver's history to be used for rating purposes. Previously a driver's history was not an element used in determining premiums.

- Breton, Transcript, at 3058

6.103 Whatever is decided with respect to surcharges -- whether based on fault or payout, how they are calculated and included -- there must be meaningful consumer education in order to ensure some degree of consumer understanding and acceptability.

(c) Deterrence

6.104 Historically, support for surcharges from insurers and consumers does not appear to have been based on any widely-held belief that surcharges function as a deterrent to accidents, claims, or convictions. As noted in Chapter 5, however, surcharges may be the only readily available mechanism to counter-balance, to some degree, through classification and rating, either the effect which possible moderation of the cost of automobile insurance will have on the decision of high risk drivers to drive at all, or the impact which the change to no fault based compensation will have on driving behaviour generally.

2. Administrative Consideration

(a) Methods of Determining Fault Today

6.105 Fault currently is determined through a variety of means such as: settlement charts; police reports; statements of the insured, parties, and witnesses to the accident; insurer judgement; out of court settlements; and court settlements.

6.106 The Intercompany Settlement Agreement (often referred to as the "fault chart") determines the apportionment of payment for third party liability property damage between insurers. In addition, it can be used along with other devices in the determination of fault in property damage claims. In Mr. Oakden's view, it could be described as "arbitrary".

- Wyatt, Transcript, at 1775, 2011
- Allstate, Transcript, at 2489-91
- Dominion, Transcript, at 4321
- Tillinghast, Transcript, at 505

6.107 In over 97 percent of third party bodily injury claims, fault is determined through out of court settlements by the insurer. However, court settlements do have a regulating influence on how insurers determine fault. Court decisions establish liability rules which govern the actions of individuals and lawyers in pursuing claims.

- Killeen, Transcript, at 5397-98
- Carr, Transcript, at 6092

6.108 Under the Board Class Plan, rating is based in part on chargeable vehicle claims as noted in paragraph 6.82. The Board indicated in Decision I-88-1D that the fault chart should not be determinative of the issue of fault, but recognized that a practical problem may exist in establishing that an insured is not at fault. It was expected that insurers would use their judgement to assign fault, in the absence of litigation.

6.109 Fault determination involves administrative and legal expenses. Claims adjustment expenses are approximately 11 percent of earned premium, which includes defense legal costs (8 percent) and adjusters costs (3 percent). The fault chart has been adopted by the majority of insurers to minimize such costs incurred in respect of property damage claims (Exhibit 13.6.1, at 522-23). The Board accepts that the bulk of these costs are expended in bodily injury claims, although it cannot determine the split.

6.110 The decision to levy a surcharge is a unilateral one made by a company based on its classification and underwriting rules. Currently, there are no legislated mechanisms for dealing with surcharge complaints. Many insurers have appeal procedures in place, of varying degrees of formality, whereby insureds can challenge a decision through higher levels of management within the company.

(b) Determining Fault in the Referred Systems

6.111 Under Options 1 and 2, where the level of bodily injury or impairment meets the defined threshold, or in choice tort, fault determination in respect of a claim will be similar to the current system. Those claims which do not meet the threshold will be treated on a first party basis with the victim's own insurer providing the benefits, as will be the case in all claims under choice no fault. Finding of fault is not necessary in order to obtain such benefits and consequently payout is not based on fault. The question arises as to whether fault will be investigated and upon what bases surcharges will be determined -- fault or payout.

6.112 Differing views were presented on how insurers would respond in a no fault environment. The difficulty is that insurers may not investigate fault thoroughly as there is a lack of economic incentive. Based on the theory of firm behaviour, it would be inconsistent to expect firms to expend resources on an activity which would not add anything to profits.

- Progressive, Transcript, at 4143-44
- Carr, Transcript, at 5920
- Hunter, Transcript, at 6775

6.113 Countering this was the view that there would be an incentive for determining fault, as levying surcharges represents additional dollars being paid to the insurer.

- Wyatt, Transcript, at 2019

6.114 Professor Priest argued that the incentive to avoid fault determination and look to payouts will increase. It was suggested that under a no fault scheme which is totally unregulated, insurers would be motivated by payouts and would charge a higher premium to those insureds where payouts were greater. The competitive process would ultimately press insurers to base premiums on expected payouts (Priest, Transcript, at 6396-97). Tillinghast appeared to agree, as Mr. Trudeau stated that "... the cardinal principle in the pricing [under no fault] is that the payout will determine the premium" (Transcript, at 512). The Board notes that if this becomes the case, the tension between consumers and companies might increase, particularly in the case of an insured involved in a not at fault accident.

6.115 While the same process as is used for determination of fault in property damage cases could be employed for bodily injury, evidence was provided that in some instances the settlement chart used by insurers in property damage cases is a matter of convenience and is somewhat arbitrary, necessitating insurer staff intervention. There is a degree of inexactitude in using this system. If in fact this process were to be used for bodily injury cases, increased vigilance in the true determination of fault would be required.

- Tillinghast, Transcript, at 499-501
- Boulanger, Transcript, at 2549-51
- Priest, Transcript, at 6556-57

6.116 Mr. Hunter correctly pointed out, however, that the determination of fault in bodily injury claims in a tort system is not exact. Although there are cases where fault is clear, there are true accidents (eg., two people changing lanes at the same time) where the surcharge arguably is based on involvement only. He was of the view that so long as property damage liability remained fault-based, the lack of incentive to investigate fault for bodily injury claims was counterbalanced.

- Hunter, Transcript, at 6675-76, 6774

6.117 Each insurer in Michigan is required by law to establish a secondary or merit rating plan for automobile insurance which includes surcharges for, inter alia, "substantially at-fault accidents" (Exhibit 6.17, M.C.L.A. 500.2111(5)). Essentially, it is up to the insurer to determine fault, based on a review of the relevant facts.

- Creamer, Transcript, at 1349-52, 1356

6.118 In New York, there is a prescribed process for the determination of fault. If the insured does not collect a third or more of his or her damages from the tortfeasor, he or she is deemed to be at fault. In the case of bodily injury, prior to a court settlement, fault is determined by the insurer.

- Reiersen, Transcript, at 756-57

6.119 Mr. Hunter emphasized that the most important feature of surcharges, particularly if they are intended to serve a deterrence function, is that they should be based on clear standards, in his view preferably clear indicators of fault.

- Hunter, Transcript, at 6775, 6878-79

(c) Data Availability and Equity

6.120 The experience of the Board, in setting industry-wide rates, is that limited actuarial data is available to support the quantification of claim-based surcharges. It is not known to what degree insurers today have appropriate and useful data on which to base claim surcharges, although there is likely to be a wide variance in the standard of data across companies.

6.121 Under the referred systems, with the exception of choice tort, not only is it possible that there will be a disincentive to collect data based on fault (which will be irrelevant to claims which do not meet the threshold and entirely irrelevant to claims in choice tort), but also that data will not necessarily be accurate, given the various ways in which fault may be attributed, as opposed to determined. While agreeing with Professors Carr (Transcript, at 6089-91) and Priest (Transcript, at 6227) that it will be difficult, if not impossible, to derive surcharges that are as accurate as in a fault system, it must also be remembered that even in a fault system there has been a lack of precision which is not trivial.

6.122 Mr. O'Donnell, particularly but not exclusively in cross-examination of Professor Priest, suggested that the surcharges for chargeable vehicle claims included in the Board-set rates could be transplanted to a threshold or choice no fault system (Transcript, at 6381-82). This approach has simplicity to recommend it, but it lacks the degree of integrity that the Board considers should be applied to these determinations.

6.123 The level of surcharges established by the Board in the Industry-Wide Hearing, and whether they were included in the rate multiplicatively or additively, were matters over which the Board took considerable care. Surcharges can be hefty -- in fact, they are one of the reasons insurance is very costly for many -- and for that reason alone every attempt should be made to avoid setting them at what could only be described as an arbitrary level. They would have to be set with regard to the significantly altered circumstances which would result from implementation of one of the referred systems, particularly if choice no fault is selected.

6.124 The problems incurred in determining an accurate assessment of fault and thus surcharges could result in serious challenges from an equity standpoint. The Board agrees that the determination of a surcharge would be an estimate at best (Priest, Transcript, at 6232-34). The question is how accurate an estimate can be made.

6.125 Challenges from a human rights or constitutional standpoint could be possible, given the lack of credible data to determine the risk propensity of individuals under an arguably arbitrary surcharge system. In Bates v. Zurich Insurance Co., a Board of Inquiry appointed under Ontario's human rights legislation found that an insurer's rate classification system was not "reasonable and bona fide". This decision was reversed on appeal by the Divisional Court as it found that the classification system did "embody distinctions supported by reasonable, actuarially verified statistics" (sub nom. Zurich Insurance Co. v. Ontario Human Rightrs Commission, (1987), 58 O.R. (2d) 325 (Div.Ct.)). It must be asked whether surcharges in the referred systems would meet this test. In addition, political pressure could result in surcharges not reflecting the true cost (Priest, Transcript, at 6224-26, 6235).

(d) Costs

6.126 A principal focus of the Reference is the degree to which the referred systems will result in decreased costs, and therefore decreased premiums. One of the prime targets for reduction is loss adjustment expenses. Tillinghast, at least, made the assumption in costing the referred systems that loss adjustment expenses decrease at the same rate as the actual losses (Oakden, Transcript, at 59-63, 7109). To the extent that the maintenance of a surcharge system requires the resources, or a portion thereof, which are now dedicated to proving or disproving fault, the costs of the systems will be underestimated, whether those costs are borne directly by insurers or indirectly through assessment for the cost of the regulatory system.

6.127 All three options will require the continued use of adjusters because, at a minimum, all three options have a third party component. Minimal savings, if any, can be expected in transaction costs for those claims either exceeding the threshold or in choice tort. The degree to which adjusters will be required in resolving first party claims, or in making fault determinations for surcharges, was not discussed with any degree of specificity at this Hearing. It is interesting, however, that in cross-examining Professor Priest on his evidence that surcharges set through a regulatory process will not necessarily be more efficient, or less costly, than through a fault system, Mr. O'Donnell appeared to suggest that the determination of fault for surcharge purposes could be done, for all claims, in the same way as it is now done for property damage claims (Transcript, at 6384-90). Thus, the settlement chart may truly become the fault chart to be used in a no fault environment.

6.128 In the Board's view, it is possible to have some savings in transaction costs in the referred systems while maintaining a surcharge system. The determinative question is the degree to which the surcharges will accurately reflect fault (assuming continued resistance to surcharges based on payout). Further, given the inherent tension between compensation on a no fault basis and rating on a fault basis, the Board is strongly of the view that a formal appeal mechanism must be made available to consumers. The statutory system of resolving disputes between insurers and insureds implemented by Michigan is a useful precedent (Exhibit 6.17, M.C.L.A. 500.2113, and see paragraph 6.124 ff.)

(e) Regulation of Surcharges

6.129 Due to uncertainties upon the introduction of a no fault system, regulated surcharges may be necessary (Miller, Transcript, at 7078-79). Moving from a fault system to a no fault system may also necessitate mandating that only at fault accidents be surcharged and that not at fault accidents not be surcharged (Oakden, Transcript, at 7154); although this will depend on the Government's attitude with respect to surcharges based on payout. The CAC, in its oral argument, supported regulating how and when surcharges could be imposed (Transcript, at 7328). It also was argued that regulating the way in which surcharges are imposed would increase comparability of premiums and consumer understanding

(Progressive, Transcript, at 4173).

6.130 It was demonstrated that a uniform classification plan is not necessarily required if surcharges are to be regulated. In New York, various rating plans are in place which must conform with the provisions set out in Regulation 100 (Exhibit 4.4.2) to its insurance laws. The Regulation is intended to encourage competition among insurers but discourage rating plans which would "create confusion or misunderstanding among insureds" and establish standards or limitations to ensure that rating plans are "reasonable, understandable, and objective and are not unfairly discriminatory, inequitable, violative of public policy or otherwise contrary to the best interests of the people" of New York State. The regulation establishes those accidents for which a driver may not be surcharged as well as defining maximum surcharges permissible.

(f) Surcharge Appeal Procedures

6.131 The increased reliance on the insurer to determine fault in a no fault environment will necessitate a dispute or appeal mechanism for insureds. While insurance companies may currently have an internal procedure for disputes, a more formalized process could result in additional costs. No evidence was provided as to the type of process required, the cost or who should bear the cost of such a system.

6.132 In Michigan, a process is in place to deal with rating problems. The process consists of the following stages in terms of resolving the dispute, with appeals to the next higher level where the dispute is not resolved (Creamer, Transcript, at 1356-61):

- Managerial level conference with insurer within 30 days
- Meeting with Insurance Bureau staff and decision by staff person
- Decision by the commissioner
- Hearing before the Insurance Bureau in front of an administrative law judge
- Court

It was indicated that the process involved minimal resources and few complaints required resolution. These characteristics might not hold true in Ontario given what could be a very different regulatory system and marketplace.

3. Commentary

6.133 Based on the evidence presented in the Hearing, the Board concludes the following with respect to surcharges:

- moving to either threshold no fault or choice no fault will reduce the incentive to investigate fault;
- it will be difficult to replicate the disciplining effect which judicial decisions provide on today's out of court settlements;
- in the absence of fault determination, or in attempting to replicate it, calculation of surcharges will be a more difficult and complex task whether performed on a company basis or by the regulatory system, which could result in legal challenges;
- in the absence of regulation, strong incentives exist under no fault to base premiums on payout, and therefore regulation of surcharges appears to be needed at least initially upon the introduction of a new system, if not continuously to ensure consumers are fairly treated;
- consumers lack understanding of and are likely to resist a system where payout is not based on fault;
- even if surcharges are established by a regulatory system, the costs thereof are likely to be less, industry-wide, than the savings in transaction costs that no fault is designed to achieve, although the margin of saving cannot be calculated;
- meaningful consumer education on the subject of surcharges will be required to help lessen the consumer pressures that will otherwise result; and,
- an appeal process should be established by which the consumer can challenge any surcharge on specified grounds.

H. CONSUMER INFORMATION AND SERVICES

1. Introduction

6.134 The needs of consumers for information and services could be analyzed in two time frames: implementation and on-going. In the Board's view, the implementation period is critical. The success of implementation will depend almost entirely on having an information system in place before the implementation date and not after. If consumers are not well-served in the transition to a new product, the attitudes to the product can quickly become chronic.

6.135 In the Hearing, Mr. Taylor of the IBAO stated that, by and large, the public does not understand anything about the automobile insurance business in the Province, and has not for many years (Transcript, at 4419-20). At best, consumers have a basic understanding of what is supposed to happen if they are involved in an accident (Transcript, at 4453). The Board thinks it likely that confusion has been exacerbated as a result of the publicity given to the decisions of the Board on matters directly affecting consumers, decisions which subsequently have been suspended. Consumers currently are hearing many things about possible products and average prices. The product and price which eventually applies to each individual may be considerably different than those in the public discussions and included in the Reference. In the Board's view, regard must be had for these circumstances which are unique to Ontario.

6.136 It would be outside the terms of the Reference for the Board to draw any conclusions on where responsibility for consumer information should rest. The Board notes that much information relating to the product is generic, and some (options, prices) is insurer-specific. The Board does make the following observations on the provision of consumer information and services.

2. Components

6.137 As part of the changes implemented on January 1, 1989, New Jersey required, by statute, that all policies (i.e., in most cases, the renewal forms) must be accompanied by a buyer's guide and coverage selection forms, the contents of which are regulated although each insurer produced its own version (Merin, Transcript, at 3429; and see examples included in Exhibit 8.9, Exhibits 4.9.3 and 4.20.5). Mr. Merin had this comment on New Jersey's efforts (Transcript, at 3462-63):

> If you have a choice system, and if people are going to make choices, the state has some responsibility, we believe, to let the people know what the facts are, what the choices mean, and in order to get across fairly technical complex points of insurance and legal language it's necessary to use a great deal of technical language in a general pamphlet.
>
> We have reviewed pamphlets put out by other states, consumer booklets on car insurance ... We view those booklets as being somewhat complex and our booklets are even more complex because of the more complex system.
>
> I think that the people ... are primarily upset by the rates, and when one considers that frustration and adds upon it a stack of material that is very complex in and of itself, I think that that compounds the confusion and the dissatisfaction.

6.138 Representatives of brokers in New Jersey confirmed that many people are unlikely to read the material. It also was noted that these materials were sent directly to insureds by insurers, and that in some cases it was suggested that insureds contact their companies, not their brokers. By definition, except in direct marketing companies, the brokers are a critical link in the flow of information and any similar problem should be avoided in Ontario through planning and cooperation.

6.139 Both New York (Exhibit 7.11) and Michigan (Exhibits 6.8, 6.16) publish periodic buyer's guides which include comparison price information. The Board had in preparation a similar publication for Ontario. Obviously, this type of publication can only come from a central source which has some authority to require that insurers disclose accurate rates. In the Board's view, it would be best if market price information could be made available to Ontario consumers prior to the implementation of product reform so that the information available to consumers would be complete. Depending on the role and form of rate regulation selected, this could require substantial lead time. Mr. Hunter also noted that information about the service characteristics of the product is relevant as many people wish to evaluate the relationship between price and service (Transcript, at 6784-85).

6.140 The Board is not familiar, in any detail, with the types of information provided by insurers to insureds on renewal, or on request. The Board notes that Michigan has statutory rules governing the content of renewal notices (Exhibit 6.17, M.C.L.A. 500.2112) which are companions to its system of resolution of disputes over rating. Any mandatory requirement to move to this type of system would have systems and cost implications.

6.141 In passing, the Board notes that product reform will require amendments to the current army of standard forms in use in Ontario today for private passenger automobiles: the application, the contract (SPF 1), the certificate of insurance (declaration page); and, possibly a number of endorsements. This, in and of itself, is a challenging task, particularly if an attempt is made to make them more readable (to consumers, and even perhaps to lawyers). One of the findings of the Osborne Inquiry was: "Taken as a whole, the standard form of automobile insurance policy is badly structured and incomprehensible" (Exhibit 13.6.1, at 134-35). Whether and when insureds will have to be provided with copies of these legal documents is something that needs consideration.

6.142 Although the threshold options are considerably more straightforward than the choice option, consumers caught in any change can be expected to have a wide range of questions which are pressing to them. Given the Board's experience in recent months with consumer telephone calls and correspondence, arrangements must be made for an adequate consumer information and inquiry service. The "wild card" in the current situation is lack of knowledge about how drivers will be classified. The greater the degree of premium dislocation, the greater the demands of consumers will be. In the Board's view, brokers, agents, industry associations, and company staff will not be able to service all consumer inquiries, even with superlative efforts, simply because of the demand a pool of six million drivers can generate compared to the time and resources which these persons have available. This will be a dramatic problem if implementation is done on a one-time, versus staged, basis. Also, consumers see value in an independent source of information.

6.143 Some other types of services have been reviewed, particularly dispute resolution methods for no fault benefits in Chapter 4 and rating disputes in this Chapter. These will only be of benefit if consumers are instructed on how to use them.

3. The Realities: Time and Money

6.144 Adding value to consumer information and services in Ontario cannot be done without adding costs to the system. Some costs already are in the system (either through insurers or through the regulatory system) and these have been taken into account in the average estimated prices. Others, likely the greater part of an improved system, have not been quantified and included. The Government and industry associations may choose to absorb some of these costs going in to a new system.

Looking industry-wide, however, the added costs can be placed in perspective. As an example, would consumers understand the payment of an extra $10 to $15 per policy, taking purposely high speculative figures, for expanded consumer information and services? For many people, this extra expenditure could result in greater premium savings, given the availability of useful price information.

6.145 In the end, timing pressures will likely exceed even cost concerns in this area, particularly if the stated implementation date of January 1, 1990 is maintained. There is a degree to which the expenditure of resources can compensate for lack of time, and services for the consumer will be dollars well spent.

I. OPERATIONAL MATTERS SPECIFIC TO THE THRESHOLD OPTIONS

1. The Role of Interpretation

6.146 The operational matters which are unique to the threshold options flow from the fact that a verbal threshold is not categorial. It is not possible, in all circumstances, to conclude solely on the basis of the words used that an injury, or the conditions arising from an injury, pass the threshold. This is a matter of degree in that some verbal thresholds might be clearer than others. Certainly experience shows that the verbal thresholds embedded in Options 1 and 2 are being interpreted and applied on a continuous basis.

6.147 The highlights of the history of interpretation in Michigan and New York have been canvassed in Chapter 3, paragraphs 3.28 to 3.33. The two most prominent operational issues which arise for our purposes are:

- what implications does the need to interpret a verbal threshold have for consumer understanding and acceptance?, and
- how serious is the possibility of erosion in the cost savings associated with the operation of a verbal threshold as a modification to a fully tort-based system of compensation?

In addition, there are several other operational issues, building on the matters discussed in Parts D to G of this Chapter, which will be briefly noted.

2. Consumer Understanding and Acceptance

(a) Overall Awareness

6.148 The evidence does not support a conclusion that a system of automobile insurance which includes a verbal threshold will be better understood, as a matter of course, than today's system. Ms. Creamer indicated that it is difficult for consumers to understand a single system based on her analysis of the Michigan threshold system over the past sixteen years. She also indicated that she had some concerns as to whether agents in Michigan were explaining the no fault benefits and the threshold properly. Mr. S. Miller, a lawyer practicing in Michigan, testified that the public does not really understand the threshold system until they get into an accident and see a lawyer. Mr. Baker, a lawyer practicing in New York and New Jersey, also testified that the general public in New York is unaware of their rights to sue or lack of rights to sue under the threshold system.

- Creamer, Transcript, at 1313, 1344
- S. Miller, Transcript, at 5712
- Baker, Transcript, at 6669-7

6.149 In the Board's view, this evidence should not be taken as a comment on a possible failing of verbal thresholds, so much as a commentary on how difficult it is, as in today's system, to provide information to consumers about the nature of their automobile insurance. It is likely that all of these comments hold true in Ontario today.

6.150 Even with that understanding, however, the need to provide adequate consumer information and services, as discussed above, on the implementation of a verbal threshold is underlined. It would be a significant change from today's product, and consumers will want to understand how it functions in order to understand how best to meet, through all products and options, their needs and those of their families.

6.151 The Board is not impressed by the current state of the industry's intentions with respect to education of their insureds after product reform. The Insurance Brokers Association of Ontario (IBAO) chose not to comment on how a threshold system might best be explained through the distribution system. The Board concludes that, while the magnitude of additional costs attributable to consumer education and services cannot be determined, they are likely to be some which will be minimal, per policy, compared to the cost of the product as a whole.

(b) Advising Claimants and Disincentives to Sue

6.152 The thrust of the testimony of the American lawyers is that it is difficult both for a lawyer to advise a client as to whether the client has a case which meets the threshold and for a lawyer to decide whether he or she should take the case (S. Miller, Transcript, at 5696; Baker, at 6618). The reason for the second comment may not be so obvious as the first.

6.153 In the American jurisdictions considered, two factors are at play. First, each party to an action must pay its own costs, unlike Ontario where, generally speaking, the losing party pays the bulk of the costs ("party and party costs") of the winning party as well as his or her own costs. Second, lawyers act on behalf of claimants, or plaintiffs, on a contingency basis. If the suit is successful, the lawyer takes a portion of the award in payment of fees and expenses. Generally, if a case is lost, the lawyer absorbs the expenses of the case. As a result, cases are "financed" by lawyers and the lawyers take a degree of risk in the result (Baker, Transcript, at 6699-6700).

6.154 It is likely that there will be disincentives for plaintiffs in Ontario to pursue cases which do not clearly pass the threshold, including ones which might ultimately be meritorious (Cherniak, Transcript, at 3757, 3822). Given the fee cost arrangements here, plaintiffs bear the risk of financing their own cases and, if they lose, the costs of the defendants as well. In fact, members of the plaintiff's bar in Ontario also generally "finance" cases until final settlement, and then are paid from the settlement. This "double exposure" to costs in a threshold dispute may be greater than the amounts for which recovery is sought given how much it costs to litigate a matter. Because there is a risk that a lawyer may not recover his or her expenses from even an average earning plaintiff who loses, lawyers may be reluctant to accept arguable cases. These disincentives will be particularly strong in the early years of the application of a threshold, as well as after certain types of significant interpretative decisions which alter the status quo.

6.155 The Government may wish to consider whether, through the rules of civil procedure or some other appropriate vehicle, a relatively speedy means of resolving whether a claim passes the threshold could be put in place, as in New York.

- Schnitter, Transcript, at 829-30

3. Erosion in Cost Savings Attributable to Interpretation

6.156 The actuarial costings of Options 1 and 2 are based on assumptions about the number of cases which will pass the threshold, and the loss and loss adjustment expenses have been reduced in accordance with these predictions. Given the "gray area" inherent in the application of either of these verbal thresholds, however, there will be losses and loss adjustment expenses which are underestimated because a certain proportion of cases at the margin, in practice, would pass either threshold. This factor is not, strictly speaking, erosion, but simply a reality that is difficult to estimate in costs. The potential for erosion through weakening or broadening of the threshold is not limited to some transition period after implementation but will be ever-present as long as there is a legal standard to be interpreted, whether by insurers or, ultimately, the courts.

6.157 There is a tendency to focus on judicial interpretation and to conclude that erosion can flow only from that source. It is likely that a threshold system will operate very much like today's system with the vast majority of cases being settled before reaching trial. Thus erosion through settlement must be considered. In fact, erosion through settlement would be particularly damaging to anticipated cost savings in the short term because, if an element of recovery for non-pecuniary damages were included in the settlement of arguable cases, the value of cases which should not pass the threshold would be inflated beyond what is anticipated. The incentive for insurers to push for settlement of cases is strong because generally the shorter the period for which a claim is outstanding, the less it costs in the end.

6.158 It cannot be concluded that erosion is an inevitable occurrence, or that it is without remedy. The following factors were identified as relevant to the degree of erosion which could be anticipated:

1. The attitude of the regulator and the willingness of insurers to take a consistent, perhaps more accurately "tough", stance on interpretation of the threshold. Mr. Reiersen indicated that in 1978 in New York insurers were told by state officials that they were expected to devote the necessary resources to uphold the threshold in litigation proceedings and they were told that a regulatory response could be expected if they did not do so (Transcript, at 675). Also, insurers were instructed not to use the existence of the threshold as a "bargaining tool" to settle cases (Transcript, at 771). Mr. Miller testified that, in Michigan, large companies will fight threshold cases whereas smaller companies may settle. There is also a question of tactics as some insurers think that if plaintiffs' lawyers are made to go to trial on every case, making it as expensive as possible, they will be discouraged from taking cases (Transcript, at 5722-24).

2. The drafting of the threshold itself. This issue has been briefly discussed in paragraphs 1.32 to 1.35.

3. Whether the interpretation of the threshold is a question of fact or law, to be decided by a judge or a jury. As noted in paragraph 3.30, this has been the subject of change in Michigan, quite apart from the interpretation of the words themselves.

In New York, as noted in paragraph 6.146, the preliminary determination is made by a judge. New Jersey has opted for the New York approach (Transcript, at 3418-19). The vast majority of cases where a judge, on summary judgement, sends a case to jury because it is a borderline case, are settled before the trial. Most insurers are willing to settle before the trial to avoid further legal fees and expenses (Transcript, at 830-31). There is a perception in New York that judges are tougher, which may explain in part why the more liberal New York threshold is performing close to the level of the Michigan threshold (Transcript, at 6659). Judge Killeen felt that thresholds would be strictly construed by Ontario judges (Transcript, at 3823).

4. Judicial attitudes to the justice of the threshold. There are at least two aspects of this point. The first is related to the measurement of injury used in the threshold, versus the manifestations of that injury for an individual. Dr. Kaplan has observed (Exhibit 19.27, at 3-4):

> Our courts seem to understand what is at stake in a personal injury litigation is the amount of dysfunction and distress and the functional disability of the injured party in their work, avocational pursuits, recreation, household management, and their personal relationships. The determination of these issues is a very different process, involving a different scientific knowledge than determining the amount of tissue damage.

The second is the degree of balance effected between third and first party benefits. The Board believes that if the threshold is seen to be too restrictive in comparison, there will be a tendency to interpret the threshold more broadly.

6.159 It must be re-emphasized that, at least from the point of view of the regulators in Michigan and New York, it is by no means clear that erosion has occurred in those states. There is concern about the effect of the DiFranco decision in Michigan, but apparent erosion may be attributable to other factors (see paragraph 3.31). Mr. Reiersen was of the view that the New York data did not indicate any erosion, and that no single case interpreting the threshold has had any measurable effect (Transcript, at 673-75).

6.160 It also is likely that attempts will be made to circumvent limitations on recovery in tort by calling in other grounds of action, which are more contract-related such as: bad faith; detrimental reliance; and misrepresentation. It should be noted that product reform, as stated, will necessitate amendments to SPF 1. Many parts of the existing SPF 1 have been judicially interpreted and the new SPF will be subject to the same type of on-going interpretation. Most American statutory threshold schemes have also been challenged relying on constitutional arguments, although these are likely to be one-time events, albeit with potentially significant consequences.

6.161 In the Board's view, the possibility of erosion cannot be ignored and, if the Government prefers a verbal threshold, serious consideration should be given to contemporaneous implementation of measures designed to contain it. In particular, consideration should be given to providing by legislation that interpretation of the threshold is a matter of law, which should be decided by a judge.

4. Other Cost Implications

6.162 There is an open question as to whether a tort system with enhanced first party benefits will cost more or less to administer than a system based primarily on third party benefits. This flows from the fact that the benefit structure more closely approximates that of an annuity, versus the lump sum basis of settlement which is common today (Carr, Transcript, at 5862-63). Insurers undoubtedly will monitor whether benefit payments continue to be appropriate in accordance with the terms of the SPF and there will be disputes over both initial and ongoing entitlement to first party benefits (Oakden, Transcript, at 573-74). A portion of these expenses will not, in fact, be new as, at present, claimants who cannot easily achieve payment of first party benefits simply rely on their third party recovery for benefits equivalent to their total loss.

6.163 Expenses currently are generated in third party claims as a result of investigation of those claims and claimants. It has already been mentioned that the use of surcharges will require the continued expenditure of some funds for investigation purposes. The enhanced importance of first party benefits, however, will also necessitate investigative expenses.

6.164 Further, there is the simple fact that files may remain open considerably longer for the settlement of first party claims, as compared to the settlement of third party claims.

6.165 There appeared to be a current underlying the evidence of insurers to the effect that they are confident that enhanced first party benefits and third party benefits over the threshold can be administered at less cost than third party benefits. Taking the evidence as a whole, the Board is doubtful about this position given the evidence in the Hearing.

J. OPERATIONAL MATTERS SPECIFIC TO THE CHOICE OPTION

1. Lack of Support for Choice

6.166 It is pointed out earlier in the Report that the choice option contained in the Reference is unique, that is, it is different from any other choice system proposed or implemented in other jurisdictions (principally New Jersey and Kentucky). While experience can assist in predicting some special aspects of the operation of choice, much of the evidence, at best, is informed speculation.

6.167 It is in the nature of a public hearing that participants will be adverse in interest on many points. That, however, does not tell the whole story about the role which the choice option played in this Hearing. Except for the albeit qualified support (in comparison to pure no fault) which it received from the Industry Coalition and a number of the larger insurers which testified, choice was viewed most negatively by participants, apart from the IBAO, which tried to take no position at all. Mr. Hunter, appearing on behalf of the CAC, may have summed up this prevalent view in the succinct heading: "Choice? Don't Choose It!" (Exhibit 30.2, at 9). Although the Board was not asked to address the overall comparative merits of any of the referred systems, the Board is of the view that the breadth of opposition to choice in this Hearing should be brought to the attention of the Lieutenant Governor in Council.

2. The Challenges Presented to Consumers

(a) The Nature of the Decision

6.168 Currently, the core coverages are both compulsory and, in the case of third party liability and uninsured motorist coverage, subject to minimum mandatory limits. Consumers select the level of benefits and the special coverages which are appropriate to their needs.

6.169 Under choice, consumers will have to choose the liability rules which will apply to them and their dependants. Much of the evidence focused on whether consumers would be able to make that decision on an informed basis.

6.170 The requirement that consumers bind their spouse and financially dependent relatives (including children who have legal capacity) living in the same home as the policyholder is worthy of comment. As a practical matter this rule will prove difficult to apply given the elastic concepts of "financial dependence" and "home". The rationale for this rule is not provided in the Reference, nor is it given in the document entitled "The I.B.C. Choice Proposal" (Exhibit 19.9). It will be remembered that insurance is vehicle-based in Ontario, not driver-based. Without some rule of this type, a major "legal Pandora's box" would be opened, with impressive cost implications arising from litigation, including intra-family litigation, and the need to ensure adequate residual bodily injury coverages. This rule, therefore, is a practical short-cut for a serious conundrum. The other principal approach -- consents or waivers -- is even less attractive. Many, principally children, would not have legal capacity to give them. A significant administrative cost would arise if consents or waivers were required. The Board agrees, however, that it is a controversial provision which would certainly be challenged. Even if it survives, it will be a source of aggravation for many consumers which will influence their attitude to this product.

6.171 Again, because policies are vehicle-based, the choice option contemplates that different vehicles in one household can be insured differently. Multi-car families are very common. As Board Counsel stated in submissions: "... you could be a tort driver going to the market in the morning and a no-fault driver going to the school concert in the afternoon, depending on the car which you choose to drive" (Transcript, at 7220). It is unlikely that this will be perceived as a benefit, and it may well be bewildering. Furthermore, mid-term policy changes are very common and tracking them will add to today's level of administrative costs. Mr. Rossi commented (Transcript, at 3601-02):

> ... when I read that [pardon] the expression, but I laughed -- I laughed so hard ... how would you keep track of it? Every time someone bought a new car and changed over, was it the wife's car, the husband's car, and even though it addressed children in here, children of whom? Children of who bought the one that was traded in. I mean, I would think that would be an absolute nightmare to try and just police or administer in any way, shape or form. I would be scared to sell a policy at that level. In fact if you didn't have an immunity in there, I don't know if I would want to. I would just tell them to go someplace else. I am serious.

6.172 As noted earlier in this Chapter it is not known to what degree benefit options will be available to consumers. The role of benefit options in increasing consumer confusion in New Jersey and the Board's view of the Industry Coalition's position on benefit options have been noted in paragraphs 6.66 and 6.67. The Board makes the working assumption for purposes of the Report that benefit options will be available so that consumers can ensure that they have purchased adequate protection. As a result, consumers will have to make a fundamental choice about the liability rules, as well as other matters. The Board is not of the view that it necessarily follows that the number of matters to be determined will replicate the number of choices in New Jersey, particularly because the medical benefits are provided through OHIP and not through an automobile insurance vehicle such as PIP, but it will be more complicated than the Industry Coalition would appear to prefer (Argument, paragraph 37).

6.173 It is difficult to predict how the requirement that both tort and no fault options be provided on a first party basis will be received. State Farm indicated that dealing with insureds on a first party basis would eliminate much of the adversarial nature of a claim, as there would be an established level of trust in dealing with one's own customer (Transcript, at 5087-91). However, it was Mr. Justice Osborne's opinion that "[T]he public, for whatever reason, does not feel safe in dealing with an insurer in settlement of a claim" (Transcript, at 6951). There is also evidence from the Michigan property damage regime, which is largely first party, that consumers are uncomfortable dealing with their own insurers when they are not at fault.

(b) Understandability

6.174 The Industry Coalition position on understandability appears to be based on the advisability of keeping the choice to the minimum one of liability rules. The following was submitted in Argument (at 18-19):

> 41. Under the **CHOICE** system, a consumer does not have to know all of the technical details. All that a consumer must be aware of is that which concerns him or her directly. Thus a consumer must be informed about:
>
> a) The various benefit levels for accident benefits under both No-Fault and Tort;
>
> b) The impact of whatever disability plans that consumer has at his or her place of employment;
>
> c) The consequences of the choice upon the ability to recover in Tort;
>
> d) The consequences of the choice insofar as spouses and financially dependent relatives living in the same home are concerned;
>
> e) The fact that under either the No-Fault or Tort options benefits are delivered on a first party basis.

6.175 The position of the Industry Coalition is, to a considerable degree, a reasoned approach to the body of vague evidence that consumers will not understand choice, but it definitely understates the problem. If one looks only at the types of information which the Industry Coalition suggests are relevant, the list is reasonably short. What is important is the underlying information which either must be provided to the consumer, or which the consumer must provide to the broker/agent, in order to come to an informed decision. The Board has already observed that the current level of consumer understanding of automobile insurance is thin and the Board does not underestimate the resources -- and particularly the "hands on" consultative time -- that will be required of brokers and agents. The IBAO indicated that some consumers may have a higher degree of understanding than others, but did not think that any consumer would have a complete understanding of all ramifications. The IBAO position is that it is not impossible for the majority of the members of the public to understand choice in its simplest terms (Taylor, Transcript, at 4398-4400).

6.176 Insurers are not necessarily so confident of the understandability of choice. In Dominion's view, choice would require a tremendous educational process for both the consumer and for the insurance company to ensure that the consumer was capable of making a properly informed decision. Mr. Perry of State Farm commented that the task of educating the consumer on the choice alternative was impossible to undertake in a standard form because people are different and people's needs vary. He opined that the brokers would have a serious problem in explaining the choices to the public. It was his belief that the government and the insurers, rather than the broker, should carry the responsibility of educating the public. Even then, Mr. Perry felt that it would be a difficult task to use standard forms to satisfy individual requirements.

- McCubbin, Transcript, at 4209-10; Perry, Transcript, at 5130-31

6.177 On the other hand, Royal disagreed and expressed confidence that a document could be written and provided to consumers adequately explaining choice, sufficient to enable the consumer to make an informed choice. Royal testified that adequate documentation could be prepared in a two page form which could provide enough information to ensure the average consumer would be protected if the choice system was implemented. The New Jersey document explaining its choice system is thirteen pages. On the other hand, Royal expressed concern regarding consumer education. It believed it difficult to legislate into the mind of an insured an understanding of his/her insurance policy. Even if the broker imparts a clear understanding of the implications of the policy to the consumer, if that person gets involved in a car accident and feels they made the wrong choice, given the particulars of the situation, there exist strong incentives on the part of the policyholder to say they did not understand the choice.

- Elms, Transcript, at 4987, 2667-68, 5008-09

6.178 It would be presumptuous of the Board, on the evidence before it, to determine that, categorically, consumers could not understand choice. That conclusion cannot stand alone, however, because the Board is of the view that the real problems are that:

- people, by nature, resist embarking upon complicated ventures even if it would be in their interests to do so; and,
- it is a feature of choice that there are risks in choosing either option. Consumers will not know until after an accident whether they have made the right choice, thereby detracting from the value of automobile insurance as protection and a source of comfort (CAC, Final Argument, at 20-21).

6.179 The evidence from New Jersey clearly establishes the likelihood of consumer resistance in Ontario. In both New Jersey and Kentucky, the legislation governing choice contains a default provision, with the result that the structure and operation of the default provision can have a significant impact on the number of insureds under a particular option. In New Jersey, approximately 75 to 90 percent of insureds are "selecting" the verbal threshold, which is also the option deemed to apply in the absence of a choice. Mr.

Rossi was of the view that some 20 to 25 percent of insureds, however, are relying on the default provision (Transcript, 3581-82; Transcript, Merin, at, 3392-93). In Kentucky, there is an option to reject no fault personal injury coverage and the limitations on the right to sue or be sued for the insured and any member of the household. A special form rejecting threshold no fault must be signed and filed with the Department of Insurance (Exhibit 10.5). Less than 1 percent of the driving population take steps to reject the threshold no fault option (Watts, Transcript, at 3208). There is no indication of whether tort or no fault would be the default provision in Ontario.

6.180 The Industry Coalition submitted, in argument, that the fact that consumers may have to make a choice about automobile insurance based on assumptions about the future is not unlike other financial decisions consumers make (Argument, paras. 38 and 39). The logic of this comparison is undeniable. The obvious difference, however, is that consumers, for whatever reasons, are much more verbal about their concerns about automobile insurance. If the present situation holds true, consumers will translate their concerns directly into political action. The choice option, therefore, may contain an inherently destabilizing element which should not be overlooked.

6.181 Further, the Board notes the cautious approach to the difficulties in consumer education raised by insurers and agrees that a major commitment of both materials and broker/agent time must be available to consumers to ensure any reasonable degree of understanding and acceptance.

3. The Challenges Presented to Brokers

(a) Duties of Brokers

6.182 Most automobile insurance in Ontario is distributed through brokers, although direct marketing companies have a significant market share. Royal, for instance, made it clear that it would be relying on its brokers to explain the choice options to its insureds (Elms, Transcript, at 2680-81). The IBAO was concerned that the responsibility for providing this education will ultimately fall on the shoulders of the brokers. Insurance brokers will be placed in the forefront in providing consumer education (Exhibit 32.1, at 4-5).

6.183 The IBAO produced in evidence a legal opinion which reviewed the nature of the duties which a broker owes, at law, to his or her clients. The opinion went further and extrapolated from these legal principles what, in practice, brokers should do in order to be able to establish that they had performed their duties in advising clients with respect to choice. The most relevant portions of the opinion are as follows (Exhibit 32.1, at 10-16):

> What emerges from this canvass of the law, is that the Courts have impressed the agent or broker with fairly strict obligations. For example, the agent or broker must have knowledge of contract law; appreciation and understanding of the insured's financial affairs and a responsibility to fulfill those obligations which he or she undertook ...
>
> To make an appropriate recommendation to a customer under the Choice proposal, the broker would be required to make an indepth inquiry into each customer's financial, health and medical status, spousal relationship, children, etc. One can certainly envision that the broker would be required to obtain the same information necessary to evaluate a person applying for disability coverage or an accident or sickness policy ... It can be envisioned that in any case where a significant injury has occurred to a person choosing the no fault option that an action would be brought against the broker for improperly advising the injured insured.
>
> In order to defend against such claims, it will be imperative for the broker to institute a set of operating procedures to extensively educate the potential insured to the fact that he is giving up substantial common law rights. In this regard, a face-to-face interview would be mandatory together with a signed declaration stating that the insured has completely understood the parameters of the election process and has knowingly given up the right to sue for damages, in all its

> ramifications, where the no fault option has been selected. In the circumstances, it would seem incumbent on the broker to interview each spouse and have each spouse sign a separate declaration in this regard ...
>
> Likewise, on renewal the broker would be required to re-interview each person purchasing insurance to ensure that the person's personal financial and medical picture had not changed sufficiently that the broker would advise a re-election to a different form of coverage.

6.184 In testimony, Mr. Taylor of the IBAO suggested that brokers would be faced with an "impossible task" in meeting their duties to their clients (Transcript, at 4362). Before discussing the only remedy which the brokers saw to this situation -- a statutory procedure and signed declaration guaranteeing immunity from legal action for breach of standard care -- other observations with respect to the role of brokers will be provided.

(b) Administrative Pressures

6.185 Mr. Dolin and Mr. Rossi testified that the New Jersey law passed in 1989 was complicated not only for the consumer, but also for the agents servicing the customer. Considerable effort has been expended by various associations in the production of pamphlets designed to explain the various laws to consumers and agents. Numerous meetings were held across the State to explain the new legislation to agents with input from the Commissioner's office. Seminars and courses were held by the various associations explaining the new laws. In addition, in-house training sessions with the agencies were held.

- Rossi, Dolin, Transcript, at 3571-77

6.186 Mr. Rossi and Mr. Dolin testified that the complexity of the choice system is further magnified at the point of distribution by the different rates and classification systems of the different companies. Any agent that is not computerized would be disadvantaged by choice due to the difficulty in providing multiple quotes under such a complex system. Mr. Dolin testified that his company had to reprogram its computer to accept all possible options and train people on its use. Without a uniform classification plan, rating rules, and data definitions in Ontario, it can be expected that similar problems will occur.

- Rossi, Dolin, Transcript, at 3576-78

6.187 Mr. Rossi estimated that prior to implementation of the new law, application processing took approximately fifteen to twenty minutes. With the new law, he estimated that explaining the basic requirements took half an hour. Mr. Rossi and Mr. Dolin testified that it took a further half an hour to complete the rating, by examining the various companies' rates, resulting in a total on average of one hour per customer.

- Rossi, Dolin, Transcript, at 3584-86

6.188 Mr. Yeates, an Ontario broker appearing on behalf of the IBAO, stated that his office currently spends about 45 minutes to an hour in processing a new automobile insurance application and policy, and 15 to 20 minutes processing a renewal (Transcript, at 4370, 4414). If the brokers attempt to alter their procedures in accordance with the IBAO legal advice, these time lines will expand significantly.

6.189 Mr. Strype, counsel to the IBAO, who appeared on the IBAO panel, estimated that the necessary procedures for placing insurance under choice would require approximately two to three hours. He also indicated that it would be a physical impossibility for a broker to talk to all of his or her clients based on the time commitment estimated (Transcript, at 4375, 4430).

6.190 It should also be noted that consumers may not understand the need for changes in broker procedures, which will be perceived by many to be onerous, particularly compared to the current level of broker-client contact in renewal of automobile insurance. Again, consumer resistance should be anticipated.

6.191 The IBAO and the Ontario Farm Mutual Association expressed concern about how the small number of insurers providing errors and omissions coverage to brokers might react to product reform based on choice. A basic level of coverage has been mandatory for brokers since October 1, 1981. Increased prices or withdrawal of already limited market capacity might result, putting added operational pressures on brokers. Further, in the case of any claim against the broker, the broker would be obligated to pay the $5,000 deductible included in the errors and omissions coverage.

(c) Statutory Protection

6.192 The position taken by the IBAO is that a statutory prescribed standard of care is necessary for two reasons (Submission included in Exhibit 32.1, at 5-6):

- to ensure that the consumer is properly informed; and,
- to minimize unwarranted lawsuits against brokers.

Mr. Strype, in his legal opinion to the IBAO, refers to what is requested as "a form of statutory immunity ... such that the brokers would be immune from suit if they performed certain administrative procedures set forth by means of regulation accompanying the required legislation." In fact the legal opinion received by the IBAO recommended that brokers refrain from participating in the marketing and sale of choice unless statutory immunity was provided to brokers (Exhibit 32.1, at 15).

6.193 Neither the pre-filed submission of the IBAO nor the legal opinion (nor, in fact, final argument on behalf of the IBAO) provided any suggestion as to the components of the desired procedures. This significant omission was consistent with the apparent sense of tactics with which the IBAO approached this Hearing. The IBC, at least, earlier had taken a position as put forward in a spirited passage in the submission prepared by Mr. O'Donnell (Exhibit 19.9, at 26, emphasis added):

> Q. Will Ontario consumers understand sufficient about the Choice of policies that they will make a rational decision as to which form of policy to purchase?
>
> A. Emphatically yes! To suggest that people who drive, work, raise families etc. cannot make an intelligent choice between two dramatically different forms of auto insurance is a slander to all Ontario consumers. All of us make very substantial financial decisions many times during a year ... To say that Ontario consumers cannot choose between two strikingly different forms of auto insurance once the

> Ontario Government lays out the choice in writing in a clear and concise fashion is akin to saying that we are functionally illiterate.

6.194 Questions put in cross-examination by Mr. O'Donnell to the panel of IBAO witnesses at the Hearing expanded on this theme (Transcript, at 4442-43):

> Q. And if the statute set out what the standard of care was, such as the brochure prepared or endorsed by the Superintendent of Insurance or this Board, whatever the case might be, had to be given to the client, and the election form, in a form prescribed by regulation, had to be given to the client, and that the duty was that the broker had to obtain the signature of the client before the client could move from tort to no-fault, if that was the standard of care set out in the statute, would that make you somewhat happier?
>
> A. That would make us somewhat happier.
>
> Q. It would be nice to have the immunity, but certainly if the statute set out the standard of care, and you were able to meet that standard of care, that would make the broker's position, if you were sued, much stronger?
>
> A. I think that what you're saying is tantamount to immunity.
>
> Q. Yes. But if you didn't see those magic words and the broker may not be sued, if it set out the standard of care and said this is the standard of care and the explanation --
>
> A. And not otherwise.
>
> Q. Right. Would that make you more comfortable, shall I say?
>
> A. It would make me more comfortable.

6.195 Finally, in argument the following proposal was made on behalf of the Industry Coalition (Argument, at 19):

> The statute should provide a standard of care for the brokers - not immunity from suit - which would provide that they must deliver a Government-approved explanatory booklet and election form to each prospective policyholder, provide a reasonable explanation to any questions asked by the client and, as well, address any peculiarities in that client of which he is aware. The Government and the Legislature thereby dictates the standard of care. A longer and more detailed brokers' and agents' Instructional Booklet would be necessary so that they could be educated in detail. Such Instructional Booklet should have a list of typical questions and answers so that they can answer clients' questions in an appropriate way.

6.196 Some inspiration for the Industry Coalition proposal may have been drawn from the New Jersey legislation, although it is not clear whether, and how, the use of an "Instructional Booklet" should form part of the standard of care. In New Jersey, the statute provides that any election of the tort option must be in writing and signed by the named insured on the Coverage Selection Form. So long as there is such an election, or the person is deemed to have elected tort under the default provision, sellers of insurance are not liable in an action for damages except in the case of gross negligence (P.L. 1988, c. 119, s.7). In reviewing the Coverage Selection Form, it does not clearly indicate that the election functions as a waiver. The Board queries whether clearer notice of this significant waiver should be given to the consumer if a similar approach is taken in Ontario. Mr. Baker was of the view that this form of statutory protection might prove to be unconstitutional (Baker, Transcript, at 6711).

6.197 In any event, Mr. Merin, the Commissioner of Insurance, made this observation in response to questions from Board Counsel (Transcript, at 3398-99):

> Q. We have heard some talk about the need for protection for agency brokers in the event of a choice system being implemented. Can you tell us what was done in New Jersey about that, please?
>
> A. [A] In New Jersey there is a form that the insured must sign, and that signature basically relieves the agent or broker of liability ... The producers essentially felt that if someone chose the verbal threshold, was then injured and wanted to sue, the -- and did not have the ability to sue because of the selection, the consumer would then sue the agent or broker, saying that the agent or broker had not explained things properly.
>
> And again, the judicial system in the United States, particularly in New Jersey, is somewhat different from the system that you all have up here. The fact is that the society in the north eastern part of the United States particularly is much more litigation minded than it is up here, and we felt that those were valid concerns.
>
> Q. When was that law implemented? Was that part of your '89 amendment?
>
> A. That was part of the most recent amendments.

Q. So there was no immunity until 1989?

A. Correct.

Q. Was there a proliferation of suits against agents and brokers after 1984 when choices were offered to consumers?

A. We have never -- very few people took that option because of the way it was structured.

6.198 Mr. Hunter posited that the support for protection for brokers is an admission about how difficult it will be to explain choice to consumers. Mr. Justice Osborne was of the view that immunizing brokers from informed consent lawsuits does not aid in providing meaningful information to consumers. Professor Carr testified that if brokers have immunity they do not have the same economic incentive to provide the best possible advice that they do when they do not have immunity.

- Hunter, Transcript, at 6787-88
- Osborne, Transcript, at 6959-60
- Carr, Transcript, at 5861

6.199 Although the IBAO advanced the importance to brokers, of statutory protection, insurers also have substantial interest in this issue as proven by the lead taken by the IBC and the Industry Coalition in proposing procedures. The direct writers, for instance, will be exposed to legal actions through their agents. These types of suits can represent a marketing problem for the particular insurance company affected as it is likely that the media would have an interest in these types of cases. Without statutory protection, companies will be under pressure from their distributors to provide support in the event of legal actions which are likely to be taken against both the insurer and the broker at the same time. Companies also will be under pressure from unsatisfied insureds. Statutory procedures cannot totally insulate the companies from these problems -- all of which have cost implications -- but they certainly would help. Further, if the Government provides the core documentation for the product, companies are not put to the expense and trouble of drafting the content of such documents.

6.200 Finally, this issue raises the familiar question of burden and responsibility: should it be shifted to the Government? The Board accepts that there would be an advantage for consumers, province-wide, to have available to them the same basic product and price information (see Part H of this Chapter) but it also does not follow that statutory protections are an essential companion to achieve that end. The Board also notes that, if such statutory protection is adopted, and if the implementation period for the new product is short, the real pressure and possibility of detriment will fall on the consumer.

6.201 The Board is of the view that, taking the evidence and argument of the IBAO and the Industry Coalition in this Hearing together, the magnitude of the problems to be created for the insurance industry do not justify such an over-inclusive remedy as the type of statutory protection put forward in this Hearing. The Board notes the arguments of Mr. Hunter, Mr. Justice Osborne and Professor Carr on this subject and recommends that, if a statutory protection is to be given, the scope of the provisions be revisited.

4. Factors Influencing Consumer Choice

(a) Rating and Adverse Selection

(1) Introduction

6.202 It will be remembered that rating is prospective. As a result, the historic underlying experience is used on a projected basis. Also, if any factor can be identified which would suggest that the risk associated with all or part of the pool will be different, then an attempt must be made to incorporate that factor. In the case of a factor which would operate to lower the risk (eg., a dramatic improvement in the crash safety features of automobiles), an insurer in a competitive marketplace would be forced to reduce premiums by some measure in order to attract customers. In the case of a factor which would increase the risk, an insurer generally would adjust the price in order to protect its profit margin. Also, as between insureds, these types of adjustments in light of the risk can inhibit cross subsidization of low risk by high risk insureds.

6.203 The degree to which these opposing factors might be at play in the choice option and how they should be taken into account in the average estimated prices were the subject of considerable controversy in this Hearing. This bundle of issues tended to be referred to as adverse selection (that is, the situation where an insured presents a degree of risk to the pool greater than that which is provided for in the premium), but not all of the scenarios suggested as possible can properly be described as adverse selection.

6.204 Determining whether both options in choice are properly priced from the point of view of the insureds who would ultimately find themselves under one pool or the other is, in the Board's view, the single most difficult, and the potentially most serious, question about choice. It has significant implications for both the level of estimated average prices and the stability of prices.

On the evidence in this Hearing, the Board can only indicate some of the major factors which will be at play. The Board makes no apology for the limited conclusions it can draw because several critical factors which would support predictions are unknown, particularly:

- how vehicles and drivers will be classified;
- whether rates will be allowed to move to adequacy;
- whether rates will be regulated in any way;
- whether companies will set rates; and
- how companies will rate choice in practice.

(2) Treatment of the High Risk Driver

6.205 Where the high risk drivers will settle, and why, may be the most useful entry point to a confusing subject. Two possibilities -- which might happen together, or one without the other -- were put in evidence. First, as discussed in Chapter 5, Professor Priest is of the view that, to the extent insurance is less expensive, high risk drivers who currently might find premiums, including at fault claim surcharges and conviction surcharges, to be too high and therefore are not driving, would commence or return to driving. As a result, the accident frequency and perhaps accident severity will increase, and claim costs and premiums inevitably will go up.

6.206 Pursuing Professor Priest's prediction, the obvious question is, to which pool will those drivers primarily be attracted or, put more generally, to which pool will high risk (or surcharged) drivers be attracted? There was no consensus on the answer to this question.

6.207 What might be called the more conventional view is that high risk drivers will be attracted to the no fault option. The Advocates Society indicated that high risk drivers will choose the no fault option for cost reasons (Exhibit 22.1, at 5). Tillinghast noted that the fact that high risk drivers may be prone to having surcharges would be an incentive to choose the less expensive no fault policy as the surcharges will be applied to a lower base (assuming the continuation of percentage surcharges) (Trudeau, Transcript, at 912-13). In addition, Tillinghast noted that there was also an incentive because the high risk driver would receive benefits even when at fault (Oakden, Transcript, at 509).

6.208 To the extent that high risk drivers select no fault under choice, the experience of such drivers in the long run would increase claims costs and consequently premiums. As a result, low risk drivers would be subsidizing high risk drivers (Trudeau, Transcript, at 510). Over time, therefore, the no fault rates would migrate upward to reflect the underlying loss experience.

6.209 Professor Carr was the primary advocate of what superficially appears to be the opposite view, but is in fact consistent because both of these scenarios are driven by the effect that underlying experience -- payout -- has on price.

6.210 Professor Carr argued that prices charged high risk drivers will be lower under the tort option than under the no fault option because, in tort, the insurer of the high risk driver would have to pay for damages only when the high risk driver was not at fault, which occurs less frequently than the situation where the high risk driver is at fault. Given that, under no fault, the insurer would have to pay for damages regardless of fault there would be higher loss costs under the choice no fault option than under the tort option, resulting in higher prices for the choice no fault option. As a consequence, the high risk driver would choose the lower priced tort option. This would also result in low risk drivers subsidizing the high risk drivers when both have purchased the tort option.

- Carr, Transcript, at 5818-19, 5836

6.211 Also, because the claims of persons injured by high risk drivers who are at fault must be paid by the insurer of the injured person in the first party format, insurers can shift losses to other insurers. If the insurers could successfully identify and market to high risk drivers who have primarily at fault accidents, they might well be in a better economic position and high risk drivers could be paying less than others for no less protection than they receive today. Professor Carr argued: "... [A] system which makes these drivers who are now on Facility sought after under the choice system has to be wrong. You just have the gut feeling it has to be wrong" (Transcript, at 5812-13).

6.212 The Board has concluded, in Chapter 4, that it accepts, as argued by Professor Priest, that choice is likely to function to change the risk profile of the driving population as a whole. In this context, that change would be an exacerbation of a problem that will exist anyway because there currently are high risk drivers in the population.

6.213 The Board does not accept that there is a likelihood, on the implementation of choice, that insurers will market the tort option to high risk drivers. This probably would remain the case, in the short term of two to three years, for two reasons. The first is that it will take some time for the industry as a whole to alter its view of the desirability of high risk drivers. Second, accepting that the industry can identify some proportion of the high risk drivers, they cannot be said to be a clearly identifiable group. Leaving aside how surcharges would function to counteract rating based on payout rather than fault, the Board is of the view that, over time, the distribution of high risk drivers will cause the rates for choice no fault to migrate upward, and the rate for choice tort to migrate downward.

6.214 Surcharges could be used to block or moderate this migration of rates. It must be recognized, however, that the surcharges will be performing what arguably is an artificial function. In the case of choice tort, remembering that it is exclusively on a first party payout basis, high risk drivers will be surcharged for accidents for which they were at fault but which resulted in no payout by their own insurer. In choice no fault, assuming that surcharges are fault based, the surcharge will be payable to the insurer of the at fault driver, whereas the greater payout may be made by the insurer of the innocent victim. As a result, evaluation of risk and rating will be divorced to an even greater degree than is present in the system today. Some insurers will profit, some will suffer, but it is impossible to predict if the surcharges can introduce any degree of balance into the choice system.

6.215 It should be noted that if classification and rate setting are company specific in the choice option, it is likely that companies will go in very different directions, certainly in the short term until the marketplace settles. This has a significant potential to contribute to consumer confusion, and it will confound attempts to determine whether there is any basic equity in the marketplace. If classification and rate making are to follow an industry-wide format similar to that under the Ontario Automobile Insurance Board Act, 1988, these matters at least will be treated consistently, although the Board believes it prudent to point out that there is so little data, and so little understanding, to assist that the results must be, at some level, arbitrary.

(3) Income Level

6.216 Wyatt calculated the average estimated prices for both parts of choice on the assumption that the pool of people under each option did not differ from the pool in the aggregate.

- Miller, Transcript, at 1756-57

6.217 Tillinghast assumed that people with lower salaries would be more likely to select pure no fault and people with high salaries would be more likely to select tort. As the maximum long term disability limit is $450 under the no fault option, Tillinghast assumed that 95% of individuals earning more than $25,000 per year (1984 dollars) (125% of $450 per week) would choose tort (Oakden, Transcript, at 77-78). Also there would be benefits from the stability of a no fault system in that the benefits would be received whether they were at fault or not and the cost of no fault would be lower. These characteristics would attract individuals without other sources of interim income in the event of an injury, and those with less disposable income (Transcript, at 374-75).

6.218 Tillinghast also assumed that 50% of the people earning less than $25,000 per year would purchase tort.

Tillinghast indicated that the reason why persons earning below $25,000 a year would choose tort is that indexation of benefits would cease when the benefits equalled two times the injured party's initial salary, which would roughly be in 14 years assuming 5 percent inflation. Mr. Oakden acknowledged that the 50% figure was arbitrary (Transcript, at 193-95).

6.219 In the Board's view, the Tillinghast assumption is to be preferred at least for the first two or three years of operation of choice. If the prices of tort and no fault, however, begin to approach each other because of risk sorting between the pools, this assumption will become less valid.

(4) Subrogation

6.220 It was noted that there is a form of cross subsidization in the current system, as insurers are not entitled to subrogate the current no fault benefits paid to their own insureds who are not at fault.

- Oakden, Transcript, at 908-09

6.221 The choice proposal goes considerably further and totally eliminates subrogation rights. The Reference does not provide a rationale for the elimination of subrogation in choice. Assuming that subrogation rights were maintained, the problem of averaging high and low risk drivers among insurers, would be resolved as costs would be apportioned to the insurer of the person that caused the injury.

- Oakden, Transcript, at 630-31

6.222 Progressive, both in its written submission and in testimony, indicated that the elimination of subrogation would lead to average prices with bad drivers paying less and good drivers paying more. It felt that subrogation was essential to the system in order that loss costs be appropriately assigned to the wrongdoers and to ensure proper rating. It also indicated that elimination of subrogation would increase the difficulty in pricing fault and no fault systems so that insureds do not gain disproportionately by jumping from fault to no fault policies.

- Rogacki, Transcript, at 4065, 4110-11; Exhibit 28.2

6.223 Progressive expressed the opinion that the elimination of subrogation would result in large insurers having a big advantage over small insurers or specialty companies. It indicated that the broader the market the more likely a company would have an average cross-section of the market.

- Rogacki, Transcript, at 4174-75

6.224 Under the proposed system (with no subrogation), the long term disability insurer, who is not part of the automobile insurance system, loses its right to subrogate. Consequently, premiums for long term disability insurers will increase as a result of increased costs.

- Oakden, Transcript, at 605

(b) Steering

6.225 Tillinghast indicated that other parties may influence the consumer in choosing between the no fault and tort options, and it is difficult to predict public reaction. The influence of marketing and sales methods employed by the insurance industry was raised. Tillinghast assumed that the underwriting process would remain neutral and that insurers and brokers would not steer consumers into one choice or another by way of broker incentives or commissions.

- Oakden, Transcript, at 420, 432-33; Exhibit 22.1, at 5

6.226 Mr. Hunter testified that even if the choice system were working in an efficient way, incentives could exist for the industry to steer people into the wrong choice for them. In Ontario, brokers' commissions are based on a percentage of premium; therefore the higher-priced option would result in higher commissions, which could influence brokers' behaviour. There is also the possibility of different commission levels for tort and no fault and in New Jersey this has been prohibited by statute (P.L. 1988, c. 156). Mr. Yeates, a member of the IBAO panel, inferred that, without a form of statutory protection, it was possible that brokers would steer business to the tort option.

- Hunter, Transcript, at 6787-88
- Rossi, Transcript, at 3586; Exhibit 8.17, at 6
- Yeates, Transcript, at 4423-24

6.227 Mr. Dolin indicated that the confusion experienced by consumers in New Jersey was increased by the actions of other groups such as attorneys, chiropractors, doctors and dentists who have a vested interest in a consumer's choice. Advertising campaigns have been launched by such groups advising consumers to contact them regarding advice for insurance.

- Dolin, Transcript, at 3593-94

6.228 In the Board's view, the possibility of steering consumers through the various means outlined is real. If any degree of rate inadequacy is inherent in the rates for either tort or no fault, steering is a virtual certainty. Steering is not just a matter of market conduct, however. Given the relationship between the risk characteristics of drivers in a pool and rates, steering could undermine the level of estimated average prices.

6.229 Progressive advocated that if the choice system is adopted, insurers should have the option to write tort or no fault policies and should not be compelled to offer both. Assuming public demand, competitive pressure would ensure that insurers offered both. This approach would add another layer of complication to the choice system. It was not sufficiently considered at the Hearing to allow the Board to draw any conclusion about whether it would be helpful to consumers.

- Exhibit 27.1, at 1; Rogacki, Transcript, at 4117-20

5. Other Cost Implications

(a) Need for Dual Systems

6.230 The choice option has attached to it administrative costs arising from the operation of two products and systems (Oakden, Trudeau, Transcript, at 570-71). The following various cost components of a dual system were identified: insurance forms and related documentation for insureds; statutory filings of information; increased rating variables, dual rating systems and hearings; enhanced or possibly separate statistical systems; and, training of systems, underwriting and claims staff to accomodate two different approaches to claims adjusting and settlement (Exhibits 21.4, 21.5, 21.6, 21.7, 21.8). In addition, an insured switching from one system to another would impose further costs at least in the form of cancellations and rewrites (Oakden, Transcript, at 589-90).

6.231 There are approximately 170 companies writing auto insurance in Ontario. The size of these companies varies significantly and impacts on their ability to expand product lines in terms of computerization and personnel. While larger companies may view the choice system as just two more products, other insurers may have difficulty in expanding their product line. Amongst the smaller companies writing automobile insurance are thirty-five farm mutuals. In a written submission, the Ontario Mutual Insurance Association indicated that the individual companies may not be able to justify the administrative expense which would accompany the choice option and the farm mutuals were not in support of it (Exhibit 21.7, at 2).

6.232 If industry-wide rates are to be set for choice, further difficulties in rating the product could be encountered. Professor Carr discussed the enormous problems and hearing time required by Bell Canada to correctly apportion fixed costs to different products. He indicated that the rate regulator would similarly be faced with trying to apportion costs and determining appropriate rates of return for the two products under the choice option. The administrative burden and costs of the regulator would increase as it would be necessary to have two rate hearings and two sets of data (Transcript, at 5839-40).

6.233 In the Board's view, these cost implications are not reflected in the average estimated costs, although they cannot be quantified with any certainty.

(b) Litigating Fault in a First Party Format

6.234 Under the current system insurers already deal on a first party basis for actions under accident benefits, the uninsured motorist coverage and SEF 44 (Chick, Transcript, at 2691-92). These disputes, however, typically involve the proof of fault and measure of damage in another action where the tortfeasor is a defendant.

6.235 Under choice tort many parties expressed concern about litigation. It is contemplated that the injured victim will sue his or her own insurer for damages arising out of the negligence of a third party. It does not appear that the tortfeasor would be a party. The insurer would attempt to prove that its insured was at fault and further, to minimize the assessment of damages. The insurer arguably is in a conflict of interest. Who will defend the insured? This is a serious problem which received little scrutiny at the Hearing. Mr. Reiersen stated that, in his view, a dual system of independent investigation and legal advice for the insured would be required (Transcript, at 696-97).

6.236 Further, there are the following significant practical problems in litigating fault in choice tort:

- How does the insurer compel the tortfeasor to cooperate in a defence?
- How do parties obtain discovery of the tortfeasor?

The situation in choice tort will be a source of real concern and frustration to insureds in that system.

6.237 It may be hoped by some that if no solution to the conflict of interest is forthcoming, the service implications for insureds will convince them that the only possible choice is pure no fault. This arguably is a very cynical characteristic of choice tort. If the choice option is seriously to be offered to consumers as an acceptable insurance product, some accommodation for consumers who must litigate these types of matters should be made.

(c) Reinsurance

6.238 Progressive testified that, under choice, reinsurance treaties would be more complicated and more difficult to price. Kingsway recommended that the rehabilitation benefits be limited to $100,000 in view of reinsurance problems for smaller insurance companies. It is difficult for the small insurance company to guard against exposure created by significant no fault benefits without significant cost increases for reinsurance. The issue of small companies encountering reinsurance problems with significant no fault payment exposure was confirmed by Royal. It should be noted that this subject also is relevant to threshold.

- Rogacki, Transcript, at 4063
- Star, Transcript, at 4629
- Elms, Transcript, at 2673

6.239 In a fault environment companies presumably are able to mitigate the added exposure of significant claims through risk selection and pricing, and hence may achieve cost avoidance through risk selection.

6.240 The Michigan Catastrophic Claims Association was set up to provide coverage for the PIP claims in excess of $250,000. This program was imposed on the insurance companies, essentially as a reinsurance pool to deal with tight reinsurance markets.

- Creamer, Transcript, at 1401

K. CONVERSION: HOW AND WHEN

1. Contract Considerations

6.241 There are implementation concerns related to any product reform. How is the new product to be introduced? Specifically, will the new product apply to all policies in force, on and after a given effective date? Or, will the implementation of the new product be phased in over a period of time, say one year to reflect the 12 month term of some of the existing policies?

6.242 The evidence before the Board is limited. Mr. Fraser from State Farm testified that the choice option would have to be on a renewal basis because each consumer would have to make a choice as to which product form they required. Threshold, on the other hand, could be implemented across all policies in force as of a given date with a pro rata price refund, if any, when the current policy expired. Zurich shared this position. In the past increased liability limits have been mandated at a specified date, while the product has remained essentially the same. State Farm's evidence was premised on the belief that threshold options would not require changes to what was purchased but rather only a change in price.

- Fraser, Transcript, at 5538-40
- Exhibit 21.8, at 3

6.243 It is not clear why the threshold options would not entail choices on the part of consumers, just as the choice option would. For example, given a minimum level of accident benefits, a consumer might choose to purchase additional accident benefit coverage or perhaps only additonal wage replacement coverage to protect against economic loss. As well, if restrictions were placed on pain and suffering below a threshold on a standard policy, perhaps optional pain and suffering coverage could be made available and the consumer might choose to purchase it. Choices would still have to be made. The threshold product is fundamentally different to the current form of insurance.

6.244 A change in the delivery system could also impact consumers' choices about companies. Service on a first party basis will take on significance and the consumer might choose to change insurers. Such a change might be based on quality of service considerations which up to now were of less importance than other criteria. It is clear that extensive consumer education will be necessary well in advance of any new product being introduced to the market. It is not sufficient to assume that consumers would not want to make choices once the nature of the new product is known.

6.245 If it is decided to implement a threshold across the board on one effective date, this can only be done by legislation as insurers could not unilaterally amend in force contracts. Assuming that this approach had the effect of levelling bodily injury benefit levels, consumers would be placed in a potentially disadvantaged position unless they were previously advised about the need to put in place specialized coverages contemporaneously with the effective date. This would place a serious short term burden on the distribution system, but the alternative is to risk consumer backlash.

6.246 Looking at the alternative (supported by Royal; Elms, Transcript, at 2638), a threshold option could also be phased in as policies renew but a residual bodily injury coverage (as this term was used in the Hearing) would be necessary to protect those people who could not sue (their policies having been converted) but who could be sued (by not at fault drivers whose policies had not been converted). Presumably the terms of this coverage would have to be determined by statute. There is, however, no obvious way to fund it and, given the nature of settlement of tort claims, the funding of the benefits would have to stay in existence for some years.

6.247 It should be noted that the average estimated prices for the choice option already contain a residual bodily injury component, but it was not designed to respond to the situation which will arise with a gradual conversion to choice. For example, if a driver with today's policy is involved in an accident with a driver who has selected choice no fault, the former remains in a position to sue the latter. As a result, the residual bodily injury component in choice is understated as it does not include the cost of suits in the transition period.

2. Insurer Cash Flow

6.248 Regardless of the adequacy of reserve levels, the Board is of the view that insurers' cash flow will be reduced by a new product, at least in the short run, where:

- the product is introduced with a price reduction;
- benefits are paid out more quickly, resulting in less available cash;
- investment income is reduced due to lower premiums and the quicker payout of claims; and
- incremental costs for implementation are incurred, such as internal systems changes, staff training, and customer education.

The evidence in Hearing I-88-1D was that there was a possible under reserving of up to $600 million in 1987. Witnesses for six companies appearing in that hearing, as well as other witnesses who appeared before the Board, expressed the view that the industry as a whole is under reserved.

6.249 An inadequately reserved company will experience cash flow difficulties (Oakden, Transcript, at 89). To the extent that an insurer is inadequately reserved, the insurer will be paying claims that arose under the old policy with cash flow from the new policy. The reduced cash flow arising from the introduction of a new policy will compound the financial difficulties of an insurer that is under reserved. Mr. Elms testified that insurers with claims that have been inadequately reserved under the old system, and with minimal capital and surplus, could face insolvency in the event of a price freeze or a price rollback upon the introduction of a new product (Transcript, at 2664).

3. Transition Time

6.250 In establishing a target implementation date, consideration must be given to the following matters: detailed definition of the product; confirmation of the classification and statistical plan requirements; computer systems development necessary in terms of rating algorithms and statistical data in order to process renewals and report activities; rates for the new policies; forms to support the new policies; education programs for staff; and education programs for the public.

6.251 The IBAO testified that a minimum time period of nine months would be required to implement any of the options and that more time would probably be necessary to implement a choice system than a threshold system.

- Taylor, Transcript, at 4503-04

6.252 Estimations as to the period of time which it would take insurers to implement any new system ranged from six months to one year, dependent upon their computer systems capability.

6.253 Allstate assumed a six to nine month time frame for system development for implementation of choice. It believed that if the product were known by July 1, 1989, it would be able to implement the choice system by January 1, 1990. This estimate was based on the assumption that either its existing classification plan remained in place or that the Board Class Plan was left intact. However, if the classification plan were to be amended, further time would be required.

- Zwaal, Kelaher, Transcript, at 2570-73

6.254 Royal indicated that a nine month time frame for systems development would be required to implement the choice system. A hearing on bonus-malus and a driver-based system were not considered in this nine month time frame, although it was assumed that a rate hearing would be necessary if the current approach to rate regulation were maintained. It was assumed that there would be no change in rating variables.

- Williams, Transcript, at 2606-07, 2640-43; Exhibit 21.5, at 2

6.255 With respect to system development, Progressive indicated that six months of vendor programming time would be required for a threshold system, once all major structural elements were known. State Farm believed that the choice system would require additional programming time, and estimated nine to twelve months in total would be required for system development.

- Rogacki, Transcript, at 4068
- Fraser, Transcript, at 5059-61

6.256 Under Bill 10, the Orders of the Board regarding the classification plan and rates applicable to it are suspended. The status of the Board Class Plan adds to the uncertainty of an implementation date for a new product.

6.257 Specific changes to the classification plan, if considered appropriate -- such as, implementation of a driver-based system or inclusion of additional variables to price accurately either the threshold or choice options -- would increase the lead time required to implement a new system. Further, if industry-wide rates are required, the Board is of the view that a minimum of six months for purposes of developing and determining rates would be required after the classification plan is settled.

6.258 Allstate testified that a period of two months would be required to develop forms for the consumer. It assumed that the Forms Committee of the Superintendent of Insurance would initiate the process with involvement from the Automobile Committee and Public Relations Committee of the IBC, in addition to the Law Society. Currently, the forms are developed by the Forms Committee and the Board.

- Kelaher, Transcript, at 2405-07

6.259 From the insurers' perspective, based on the estimated critical path for implementation, and given that many procedures will be going on coincidentally, computer system development time of up to twelve months appears to be the major constraint.

6.260 The Government should be cautious when assessing industry estimates with respect to administrative matters and system implementation. Evidence provided to the Board in August 1988 in the Industry-Wide Hearing indicated that June 1, 1989 was a reasonable date for the implementation of a new uniform classification plan and statistical plan, undertakings not unlike the changing of a product in terms of difficulty. History speaks for itself. The industry is generally captive to a few computer system vendors who, perhaps for reasons of resources, have not displayed a capacity to respond to tight deadlines. All companies did not react with the same degree of cooperation and timeliness to changes imposed by the Act, again possibly for reasons of resources.

6.261 In the Board's view, the industry time estimates, with the exception of that of the IBAO, do not sufficiently account for the educational demands of transition to a new system, particularly if it is choice. The Board's response to the industry evidence is as follows (regardless of whether contracts are converted across the board or on renewal):

- if the regulatory schemes in the Act are maintained, necessitating public hearings on both industry-wide classification and rates, a threshold system could not be implemented in less than nine months from the date the statutory provisions are fully known because education time must be allowed following the decisions in the hearings;
- if the regulatory scheme is changed, and in particular if companies are largely unregulated as to classification and rates (i.e., no prior regulatory approval of rates), a threshold system could be implemented in an absolute minimum of six months from the date the statutory provisions are fully known, allowing sufficient time to educate consumers and allowing them to order their affairs, although this would place a strain on the distribution system and service levels; and,
- choice should not be implemented in less than one year from the date the statutory provisions are fully known, and could not be implemented in a shorter period if public hearings on classification and rates are required in addition to adequate education time.

L. COST RELATIONSHIPS BETWEEN AUTOMOBILE INSURANCE AND OTHER PAYMENT SCHEMES

1. OHIP Utilization

6.262 There was testimony from witnesses that under no fault systems where insurers will be monitoring claim payouts rather than determining fault, there will be an incentive for insureds to minimize the claims they make against insurance companies. They can accomplish this, in part, by utilizing OHIP services rather than private health care services. Although evidence was presented that increased utilization would be a burden on OHIP, no witness could quantify the effect of these actions.

- Carr, Transcript, at 5836-37, 6059; Exhibit 19.3(a), at 5
- Oakden, Transcript, at 515, 518-21

6.263 Professor Carr stated that insurers always have an incentive to direct claimants to use OHIP services as the payment for all services is provided under the OHIP subrogation agreement and does not require a separate payment as required under private health care services.

- Carr, Transcript, at 5837-38

6.264 Representatives of Allstate did not agree with this assertion and testified that it would be against its corporate policy to direct claimants to utilize only OHIP facilities.

- R. Rogers, Transcript, at 2266, 2373-79

6.265 Based on evidence filed by counsel for FAIR, Mr. Fraser of State Farm testified that the evidence indicated that State Farm currently has a preference for claimants to utilize OHIP facilities if they are available.

- Fraser, Transcript, at 5500-06
- Exhibit 19.17(a)

6.266 It was also Professor Carr's evidence that under the proposed no-fault systems, insurers would have an even greater incentive to direct individuals to utilize OHIP services as a result of providing enriched accident benefits. The additional burden on OHIP services would lengthen waiting times for patients and delay rehabilitation.

- Carr, Transcript, at 5837-38, 6060

6.267 It was the testimony of Tillinghast that prolonged rehabilitation caused by longer waiting periods posed an additional cost to the insurance system which could possibly result in increased premiums.

- Oakden, Transcript, at 524-25

6.268 In addition to the question of utilization, there was conflicting evidence as to the effect on OHIP and private health care services of improved accessibility and delivery of enriched accident benefits. Dr. Corey testified that unless accessibility and delivery of accident benefits were improved under the proposed systems, the utilization of enriched benefits would not increase. If the proposed accident benefits were made more accessible both through education of physicians of the range of available services and integration with OHIP, Dr. Corey stated that there was a potential for growth of specialized rehabilitation clinics and services.

- Corey, Transcript, at 4012-17

6.269 Alternatively, Professor Carr testified that improvement of access to benefits provided by non-OHIP services would not automatically lead to an unburdening of OHIP services. Insureds may still have an incentive to use OHIP services to minimize claim payouts and maintain stable premiums.

- Carr, Transcript, at 6060-61

6.270 In terms of the types of services affected, it was Dr. Corey's testimony that increased utilization of rehabilitatition services over the current limit of

$25,000 would occur only in the case of the most serious paraplegic, quadriplegic, multiple missing limbs, and severe head injuries.

- Corey, Transcript, at 3952-54

6.271 Professor Carr stated that one result of insureds seeking OHIP services to reduce claim payouts would be to increase utilization of the services of those psychiatrists and physiotherapists operating under OHIP rather than privately.

- Carr, Transcript, at 5969-71

6.272 On balance, the Board concludes that product reform of the nature of the referred systems will increase OHIP costs. These costs could be funded by the OHIP scheme generally, or the bulk subrogation agreement could be renegotiated to reflect them.

2. Growth in Rehabilitation and Long Term Care Services

6.273 A number of witnesses testified that an increase in the level of benefits for rehabilitation services and long term care would lead to a growth in specialized services and facilities. In the costing of the three proposals, Tillinghast estimated a 25 percent increase in utilization as a result of enhanced rehabilitation and long term care benefits.

- Corey, Transcript, at 3950-51, 3978
- Rempel, Transcript, at 4746
- Chick, Elms, Transcript, at 2698, 2706-07
- Oakden, Transcript, at 916-17

6.274 Mr. Cherniak did not believe that enriched benefits would lead to growth of rehabilitation services since the facilities would require subsidization. It was his opinion that these facilities would not be able to operate on a profitable basis since the income of injured persons was not assured.

- Cherniak, Transcript, at 3811-12

6.275 It was the submission of State Farm that enrichment of rehabilitation and long term care benefits would lead to greater utilization and would ultimately increase costs to consumers. As a cost control measure State Farm recommended that a schedule for rehabilitation benefits and similar services be implemented to provide consumers with price stability similar to the workers' compensation medical fee schedule used in New York.

- State Farm, Submission, at 3

6.276 A representative from Pennsylvania also testified that a system has been proposed similar to the U.S. Federal Government's Medicare system which determines "customary, prevailing and reasonable" fees in order to place limits on medical costs. New York has an established medical fee schedule. New Jersey has statutory authority to proclaim such a schedule, but Mr. Merin stated that it was understood that it would not save much money.

- Reiersen, Transcript, at 654
- Powers, Transcript, at 3337-39
- Merin, Transcript, at 3472

6.277 As a further containment of costs, State Farm recommended that all services of physicians should be specifically stated by regulation rather than using tests of "reasonable and necessary" services as contained in Michigian no fault legislation. Further, it supported the retention of independent medical examinations of claimants to ensure the "reasonable genuineness" of claims.

- Perry, Transcript, at 5056; Submission, at 3

6.278 Dr. Corey provided evidence as to the current regulatory environment in the rehabilitation services field. He stated that there is a very weak governing body regulating this sector with a certification process which is entirely voluntary and which does not have stringent criteria. Dr. Corey also pointed out that, as a result of the current adversarial legal environment, a dichotomy exists within the profession separating the rehabiliation specialists working for claimants and insurers.

- Corey, Transcript, at 4020-22

6.279 Dr. Corey agreed that there are developments within the rehabiliation field which must be looked at in assessing how these services would be provided in a new environment. He also stated that regulatory mechanisms implemented in U.S. no fault jurisdictions to protect against price gouging were not required in Ontario due to the functioning of OHIP.

- Corey, Transcript, at 4022-23

6.280 In answering the issue of how to establish consensus between specialists as to the rehabiliation requirements of claimants in a tariff situation, Dr. Corey recommended that a range of costs be established. He also advised that a cost benefit analysis system similar to that used by the Workers' Compensation Board be used to evaluate the success of rehabiliation programs.

- Corey, Transcript, at 4024-27

6.281 It was the submission of ARCH that non-medical rehabilitation and long term care services should be supported through bulk subrogation funding by motor vehicle accident insurers as is currently provided for medical services under OHIP.

- Final Submission, at 40,48

6.282 The outstanding question, therefore, is the degree to which pressures will arise to regulate and fund rehabilitation and long term care services on a different basis than in place today.

3. Utilization of Public Income Support Plans

6.283 It should be noted that the authors of the Econanalysis study did not undertake to assess the adequacy of benefits under the current social programmes in order to determine overall whether there would be more people dependent on these programmes. They simply examined the adequacy of the no fault benefits under the proposed systems. Section 4 of the study stated that overall the proposed benefits would generally provide sufficient coverage so that significant indirect costs would not be imposed on other income support plans.

- Exhibit 31.1, at 41; Evans, Transcript, at 5576-77

6.284 In order to estimate those individuals and families at risk of relying on Gains-D and General Welfare Assistance programmes, the Econanalysis study undertook the following process. For the following cases -- unattached individuals, families of four and single parents with two children -- Econoanalysis estimated the percentage of these groups who had pre-accident income levels which were less than 120% of maximum eligible earnings under the two programmes. The rationale used is that, under the proposed schemes whereby no fault benefits generally provide injured persons 80% of pre-accident income, a reduction of 20% in income after a disabling accident would place individuals at an income level where they would be eligible to receive assistance under these programmes. The study concluded that 20.3% of unattached individuals, 11.6% of families of four and 47.5% of single parent families are at risk of requiring a top-up to their income under these plans as a result of a permanently disabling automobile accident.

6.285 The study further quantified the number of individuals who own vehicles within these three groups and could require compensation under Gains-D and General Welfare programmes.

- Exhibit 31.1, at 42; Exhibit 31.1(a), at Table 4.2.5

6.286 The study provided further illustrative examples where a "top-up" in income level was available from the Family

Benefits Allowance or Gains-D programme (Exhibit 31.1, at 41-42). As pointed out in the study, only those individuals who are assessed as being permanently disabled would qualify for assistance under this programme:

a) an unattached individual earning $9,880 annually would receive General Welfare Assistance for one week and $16 per week under Gains-D if permanently disabled (Exhibit 31.1, Table 4.2.1);

b) a single parent family headed by a female earning $14,560 annually would receive General Welfare Assistance for one week and a top-up of $48 per week under Gains-D (Exhibit 31.1, Table 4.2.2); and

c) a family of four with a single income earner and two children with an annual income of $15,600 annually would be able to receive $46 per week from Gains-D in addition to one week of General Welfare Assistance (Exhibit 31.1, Table 4.2.4).

6.287 In the final segment of section 4 of the Econanalysis study, two situations were identified where injured persons would be forced to rely on other income support plans as a result of their ineligibility to receive the proposed no fault benefits. The study included individuals who currently receive social assistance and unemployed individuals who are not deemed employed (i.e., have not worked for more than 6 months out of the last 12). The study pointed out that generally those individuals dependent on social assistance usually do not remain in these programmes over their lifetime. In addition, statistical evidence supports that unemployed individuals are unlikely to remain permanently unemployed and will likely have only spells of unemployment. Given that these individuals would receive no compensation under the proposed schemes, there may be an additional burden placed on these programs as a result of longer term dependency by disabled individuals in these two groups.

- Exhibit 31, at 36, 43-44

6.288 In addition to Econanalysis, Tillinghast testified that its costing of the proposed no fault systems did not take into account the potential shifting of the burden to social service agencies in those cases where individuals would be inadequately compensated. The specific case highlighted was a family of four where the primary income earner was fatally injured in an automobile accident and the only source of income was the death and funeral benefits of $55,000 under the proposed systems.

- Oakden, Transcript, at 98-102

6.289 It must be noted that it is likely that some individuals and families involved in automobile accidents would be forced to look to public income support plans today. Some would be innocent victims injured by an uninsured driver (taking into account the operations of the Motor Vehicle Accident Claims Fund) or by a driver with low third party liability limits. Others might be at fault drivers who had exhausted their Accident Benefits. All in all, it would appear that the costs to taxpayers generally will not significantly increase as a result of the change in the automobile insurance product. Rather, the problem is one of level of recovery as discussed in Chapter 3.

M. OVERVIEW OF ADMINISTRATIVE BARRIERS AND COST IMPLICATIONS

1. Administrative Barriers

6.290 In the Board's view, the evidence indicates that there are no true administrative barriers with respect to the implementation or on-going operation of a verbal threshold system. As noted in Parts B to H and K of this Chapter, however, there are significant questions -- relating to rate regulation; benefit and coverage options; classification and surcharges; consumer information and services; and, the approach to contract conversion -- which merit consideration and decision. Answering these questions, and implementing whatever measures are chosen to accompany product reform may strain the available public and industry resources, and may absorb more implementation time than anticipated. Each of these items is capable of resolution and could be said to contribute an administrative pressure rather than a barrier.

6.291 Considering the choice option, the immediately above-noted comment applies equally and, in addition, there are five matters which might operate as barriers. They are: (1) consumer understanding and acceptability (Part J, section 2); (2) the indicated response of the brokers in the event that a form of statutory protection is denied (Part J, section 3); (3) the possibility that there is not sufficient capacity in the distribution system to fully advise all Ontario drivers on the choice option (Part J, section 3); (4) the significant degree to which the pricing of both options in choice will be inequitable (Part J, section 4); and (5) the difficulties to be encountered in litigating fault in a first party format (Part J, section 5). Given significantly more lead time and substantially more resources from the public and private sectors than required to implement a threshold system, even these features are surmountable in so far as implementation is concerned.

2. Cost Implications

6.292 It has been noted throughout this Chapter that costs which were either underestimated or excluded from the calculation of the average estimated prices can be identified but not quantified with any useful degree of precision.

6.293 Today, some automobile insurance regulatory costs incurred by the Government are funded from general public revenues, and some are assessed for payment by the industry. Quite apart from not knowing how the Government will adjust the regulatory system, the Board cannot speculate as to whether costs incurred by the Government as regulator will be absorbed or assessed. Regardless of how the costs of the regulator are funded, each company has costs of compliance which it must bear. The conclusions of the Board with respect to specific cost implications exclude these regulatory and compliance costs because they cannot be identified and allocated at this point, although they are real.

6.294 The principal underestimated or excluded costs which pertain to the average estimated prices of each of the referred systems on implementation include (in random order):

- movement to rate adequacy
- possible enrichment of benefit levels
- the set-up costs of a system of alternate dispute resolution for certain first party benefit disputes
- the set-up costs of a system of resolution for rating disputes, particularly surcharges
- adequate consumer information about the new product and how it can affect the individual, particularly in the case of the choice option
- adequate consumer price and service information (including any new ADR system and rating dispute system)
- consumer inquiry services
- provision of advice on contract conversion and availability of benefit and coverage options
- a new reinsurance pool for first party benefits
- provision of new contracts and relevant endorsements to insureds on contract conversion
- depending on approach to contract conversion, a short term residual bodily injury coverage to protect those whose contracts have been converted from those suits initiated by those whose contracts have not been converted
- the cost of computer conversion, particularly in choice
- the cost of collecting and maintaining additional data, especially in choice

6.295 The principal underestimated or excluded costs which pertain to the average estimated prices on an on going basis include (in random order):

- movement to rate adequacy

- adjustment of base benefit levels to address inflation, if any
- the running costs of a system of alternate dispute resolution for certain first party benefit disputes
- if claim surcharges are retained, reduction in loss adjustment expenses unlikely to be proportionately equivalent to reduction in losses
- the running costs of a system of resolution for rating disputes, particularly surcharges
- adequate consumer information about the product in the form of a significant on going campaign in the case of choice
- periodic consumer price and service information
- in a choice system, the costs of a dual system
- in choice tort, the costs of resolving the conflict of interest inherent fault-based disputes in a first party delivery format
- the cost of collecting and maintaining additional data, especially in choice

6.296 Finally, the Board concludes that the costs to OHIP will increase under any of the referred systems, and that there will be pressures to regulate and fund rehabilitation and long term care services on a different basis than today.

7. PRICE STABILITY

A. SCOPE OF THE QUESTION

7.1 The question which the Board considers in this Chapter is whether there would be greater stability in the average prices charged for automobile insurance policies after implementation of the systems. A review of the features of this question may be useful.

7.2 The term "stability", as utilized in the Hearing, suggests two different bases of comparison. The first concern was whether the cost changes in moving from one type of product to another were sustained. The second concern was the pattern of cost changes flowing from the implemented product, that is, after any one-time percentage cost savings on conversion is taken into account and a new base for prices is established.

7.3 The reference to "average prices" is important. As the Board was not asked to consider any aspects of the prices to be paid by individuals, the Board does not comment on what might influence stability of the premiums charged to individuals. This is, in and of itself, an important question because it is well known that instability of premiums is particularly frustrating to consumers.

7.4 As noted in Chapters 1 and 6, many attributes of the insurance system which ultimately is to be wrapped around the standard form of contract are not known at this point. The implementation and operation of the various parts of the system could influence stability in minor or major ways. An important example is that the evidence addressed the private passenger automobile insurance market as a whole, without distinction between the voluntary market and the residual market (the Facility Association). As a result, this Chapter will not focus on predictions about stability so much as it will on the principles relevant to stability.

B. DYNAMIC FORCES DETERMINING STABILITY

7.5 Any discussion of price stability is faced with a practical challenge. The degree of stability is not a product of discrete linear forces which can be readily identified and measured. Rather, it is the product of dynamic forces which combine, and sometimes change, in different ways over time, producing different effects. The major forces will be identified.

1. Frequency and Severity of Losses

7.6 Historically, the frequency and severity of claims are the starting point for pricing as competition has forced pricing to bear a relationship to cost. In fact, as the premiums for third party liability - bodily injury today constitute about 50 percent of total final premiums, the frequency and severity of bodily injury claims are very significant.

7.7 As amply illustrated by the issues, evidence and Decision in I-88-1D, frequency and severity on an accident year basis may show changes from year to year, and a numerically small increase in either may have a significant effect on total costs and total prices. This relationship is confirmed, for the referred systems, by the analysis in Chapter 8. The effect on the average estimated prices for each system is calculated, for illustrative purposes, using 5 and 10 percent increases in accident frequency which underlies claim frequency.

7.8 Frequency is not measured by dollars and therefore is superficially comparable on a constant basis from year to year, although the underlying reasons for changes in frequency can be many and complex. An extended example is provided in the review in Chapter 5 of the relationship between automobile insurance changes in Québec and accident frequency. Again, the determination of the average estimated prices for the referred systems presented in Chapter 8 looks at these items on implementation.

7.9 Severity is based, in part, on the dollar value of total reported incurred claims and therefore is not superficially comparable on a constant basis from year to year. The dollar value of total reported incurred claims depends, in large part, on the types of benefits, level of benefits and utilization of benefits. Also, the dollar value of total reported incurred claims includes both loss and loss adjustment expenses, although the former dominates.

2. Operating Expenses

7.10 Operating expenses, sometimes referred to as delivery or transaction costs, represent a much smaller proportion of final premiums. Decision I-88-1C reports that there is evidence that these expenses have been declining proportionately. Operating expenses, however, cannot be considered immaterial in the context of product reform because, as noted in Chapter 6, some operating expenses will be reduced, some will be increased and some new ones will be added.

3. Prospective Pricing

7.11 A critical product feature of insurance is that the principal part of the expenses to provide the product and related services are paid in the future, but a value must be placed on them in the present in order for the product to be sold. Although retrospective rating is available for some commercial automobile lines, it is rarely, if ever, used in private passenger automobile insurance.

7.12 As a result, costs for the future period must be estimated. There is always a degree of uncertainty as to how close the estimates will be compared to actual experience.

4. Competition Among Insurers

7.13 Competition was one of the issues reviewed in Decision I-88-1C. Competition has two important implications for price stability. As consumers are price sensitive and as there is evidence that price level and market share are related, company officials are very much influenced by the anticipated effects on competitiveness that prices may generate. Also, to the extent that regulatory and consumer initiatives will improve the price and service information available to consumers, competition could increase in the future.

5. General Economic Conditions

7.14 Economic conditions are omnipresent in determining price stability because they influence all of the above noted factors: accident and claim frequency and severity; operating expenses; pricing decisions and competition. In recent decades, the point in the inflationary/recessionary cycle at which the economy finds itself is a particulary important general indicator.

6. Nature and Extent of Regulation

7.15 The types of regulation referenced under this heading go well beyond the insurance regulatory infrastructure reviewed in Chapter 6. Many types of regulation affect the ultimate level and stability of automobile insurance premiums. For instance, there are many laws governing driving behaviour which may or may not have an effect on accident frequency and severity. The Gaudry and Devlin studies discussed in Chapter 5 consider the effect, in Québec, of lowering speed limits and making seat belt use mandatory. There are also laws governing many product or service suppliers to the industry, e.g., auto body repair shops and the health disciplines. Often, these regulatory regimes can be restructured without any reference, in public policy terms, to automobile insurance and without any degree of consumer understanding of the pricing implications.

C. PRICE STABILITY IN ONTARIO PRIOR TO APRIL 23, 1987

7.16 The lack of price stability in the Ontario automobile insurance marketplace in this decade is widely perceived to be one of the pressures behind the introduction of the Act. Chapter 7 of the Osborne Inquiry Report provides an in depth review of the relationship between loss costs and premiums (for separate coverages, and for total premiums, using constant dollars, for the period from 1975 to 1986). This analysis is commended for its thoroughness and depth. It is cited here for two particular reasons.

7.17 First, it presents virtually a present day example of both how the above noted factors function to influence pricing decisions and prices, and the destabilizing effect which developing rate inadequacy has on rate stability over the short term. Although it is difficult to capture the essence of Mr. Justice Osborne's analysis in one excerpt, the following is helpful:

The insurers' explanation that a substantial premium increase in 1986 was required to bring premiums into line with increasing bodily injury loss costs requires some examination. At the outset, even using discounted reserves, I note that it was in fact necessary to increase premiums in 1986. The root cause of the problem occurred much earlier. Premiums were declining from 1977 to their low point in 1981. Loss costs, as indicated, increased moderately in the same period. Loss costs increased steadily and relatively substantially from 1982 through 1985. In this period, third party liability premiums remained stable. There is likely no single explanation for the steady decline in third party premiums between 1977 and 1981. One plausible explanation is that third party premiums were too high in relation to expected loss costs at that time. Another explanation is that high interest rates of the late 1970s and early 1980s encouraged insurers to be less vigilant in their concerns about expected loss costs than might otherwise be the case. This is the cash flow underwriting syndrome.

By 1982-83 two compounding problems became visible, at least with the benefit of hindsight. First, interest rates began to decline; second, bodily injury claims costs increased, at least in part due to the somewhat late blooming effect of the 1977-78 legislation which introduced prejudgment interest and expanded access to non-pecuniary compensation through the F.L.R.A. Generally, the insurance industry took no real account at any time, and particularly in the early 1980s, of the probable impact of prejudgment interest and F.L.R.A. claims. Even now, insurers do not for the most part capture data as to what is being paid to bodily injury claimants for prejudgment interest or under the F.L.A. Insurers did not take reasonable account of the probability that claims costs would necessarily increase once the recession of the early 1980s ended and relative prosperity returned. The industry collectively responded with a substantial premium increase in 1985-86. If the increase had been introduced gradually, there would have been fewer and less intense complaints.

- Exhibit 13.6.1, at 283, 285

7.18 Second, the Osborne Inquiry Report is illustrative of the fragile nature of predictions in this area. Mr. Justice Osborne stated, as one of a number of conclusions (at 296): "I think it is reasonable to forecast that accident frequency in the short future term should be stable at worst." Even assuming that accident frequency, as opposed to claim frequency, was meant, this conclusion is problematic.

7.19 As noted in particular in Part C of Chapter 6, claim frequency significantly increased in 1987 and 1988, putting upward pressure on rates. Accident frequency is a principal component of claim frequency. In the attempts to explain the increase of claim frequency, the role of accident frequency is unclear. The conclusion drawn by Mr. Justice Osborne may be empirically correct (it is not intuitively appealing in today's circumstances), but it is interesting that it has not been established at least for 1987 and 1988.

D. CONCLUSIONS DRAWN FROM EXPERIENCE IN U.S. PERTAINING TO THRESHOLD NO FAULT STATES

7.20 The principal evidence on price stability in U.S. states was given by the following witnesses: representatives of the State regulators in New York (Mr. Reiersen), Michigan (Ms. Creamer) and New Jersey (Mr. Merin); Messrs Bryan and Smith of Ernst & Whinney; Professor Priest; and, Mr. Hunter. Reference was made to the U.S. Department of Transportation 1985 study entitled "Compensating Auto Accident Victims" (Exhibit 14.6) which was discussed, in general terms, in Chapter 3.

7.21 The Board has drawn the following conclusions from this evidence:

1. Over time, private passenger automobile insurance premiums in the U.S. threshold states do not move downward or stay flat but are moving in an upward direction as in Ontario.
   - Exhibit 14.6, at 71

2. There is no proof that price increases in threshold no fault states are more moderate than in other states. At best, comparing groups of states with similar products, the increases over time are more or less equivalent.
   - Exhibit 14.6, at 70
   - Hunter, Transcript, at 6813-14
   - Bryan, Transcript, at 2816
   - Priest, Transcript, at 6247

3. There is evidence that price increases in threshold

no fault systems can be significantly greater than in states with other types of products, but the possible reasons for this are many, and can vary from state to state. The role of the threshold itself, therefore, is very difficult to extrapolate.

- Exhibit 14.6, at 86-87
- Bryan, Transcript, at 2844
- Priest, Transcript, at 6248-49

New Jersey is the obvious example of a state with price increases which have significantly exceeded other no fault states and tort states. The proferred reasons for this in New Jersey include: the population density of the state; litigiouness of citizens; unlimited medical benefits; continuing rate inadequacy; and, increased utilization of benefits.

- Merin, Transcript, at 3381, 3383-85, 3472
- Exhibit 8.8
- Bryan, Transcript, at 2829-30

4. There is evidence that, comparing the threshold no fault systems particularly studied in this Hearing, each of them results in similar percentage increases over the long term. Interestingly, price increases in New York have been below the national average and more stable over the last 5 years, while those in Michigan have been slightly above

the national average and less stable

- Bryan, Transcript, at 2763, 2776-77, 2883-84, 2888
- Hunter, Transcript, at 6942-43

5. There is opinion evidence that, at least with respect to Michigan, price increases would be less stable in a tort system than in the verbal threshold system.

- Smith, Transcript, at 2854

6. There is some evidence as to what might contribute to increased price stability. The factors include:

. rate adequacy for the benefits provided;

- Reiersen, Transcript, at 813
- Bryan, Transcript, at 2988
- Priest, Transcript, at 6339-40

. controls on the charges for products and services related to the benefits, eg., medical fees; and

- Reiersen, Transcript, at 677
- Creamer, Transcript, at 1290

. claim severity becomes less a function of socio-economic factors, as in tort awards, and more a function of economic indices, thereby reducing "social inflation", with the result that the value of claims is easier to predict.

- Smith, Transcript, at 2892

E. CONCLUSIONS PERTAINING TO THE REFERRED SYSTEMS

7.22 There are two fundamental conclusions which apply to all of the referred systems. The first is that changes in average prices do not mirror changes in average costs. Although there is a relationship, prices are influenced by all of the factors in this Chapter. In fact, the period of rate instability which occurred earlier in this decade, as analyzed by Mr. Justice Osborne, would not have been so serious if prices had tracked cost developments and been less influenced by other factors. Costs, in any given period, may not even be dominant in determining prices.

7.23 The second is that rate stability should not be understood to mean flat prices. Loss costs alone are anticipated to increase annually in double digit amounts. The question, therefore, is whether price increases will be stable.

1. Threshold Options

7.24 The Board draws four conclusions based on all of the evidence before it. The first is that, assuming insurers are unrestricted in rate setting and assuming no new regulatory measure of dramatic effect, there is likely to be instability in average estimated prices in the short term (one to three years) because: (1) accident frequency is anticipated to increase as noted in Chapter 8; (2) some loss adjustment expenses and operating costs have been underestimated or excluded from the estimation process as noted in Chapter 6; (3) even if rates move toward adequacy, they will move gradually as capacity and high levels of competition are unlikely to return immediately; (4) insurer approaches to rate setting in the move to rate adequacy cannot be predicted; (5) given the current less significant role played by first party benefits, there is limited experience with where unwarranted costs will arise and the remedial measures to be implemented; and (6) there will be limitations on the usefulness of the data available for purposes of making rates for a new product, resulting in even greater limitations or precise estimation.

7.25 The second conclusion is that, unless the form of rate setting is industry-wide, rate regulation will be of limited effectiveness in assisting in increasing rate stability. If the form of rate regulation were to be company-specific, it may be possible to provide industry-wide standards against which to judge each company.

7.26 The third conclusion is that without the liberty to move to rate adequacy or a rate regulatory system premised on movement to rate adequacy within a defined time frame, rate inadequacy will be the most serious impediment to reaching rate stability.

7.27 The fourth conclusion is that in the mid to long term, assuming the existence of rate adequacy, rate stability will be more influenced by the combined effect of calibrations to the system to assist it in functioning efficiently than by the existence of a verbal threshold itself. A verbal threshold, however, may facilitate the calibration process because a restriction on legal rights already has been implemented.

2. Choice Option

7.28 The Board does not draw any conclusion with respect to rate stability under the choice option. While either the tort or no fault option is capable of approaching rate stability as long as rates are adequate, together, in choice, these options present an inherently unstable base. It cannot be determined with any certainty how the options will be priced or what types of drivers will be attracted to either pool. Further, constant shifting between the pools, province-wide, is likely.

7.29 The dominant feature in determining rate stability in the choice system, therefore, will be the composition of the tort and no fault pools from time to time and, as the system currently is structured, that is likely to be unstable.

8. ESTIMATED AVERAGE PRICES

A. INTRODUCTION

8.1 Pursuant to the terms of the Reference, the Board was given the task of estimating the average prices that would be charged for policies within the three proposed systems of privately delivered automobile insurance, based on the Board Class Plan, and the determinations of fact and rates established by the Board under Decision I-88-1D. In practical terms, this task amounted to a determination of the percentage change for the average price estimated at the Board's benchmark rate level (the benchmark rate) that would result in each case if each of the proposed systems of automobile insurance were implemented.

8.2 The nature of the task was to complete an actuarial calculation of these prices. The first part of the task was to ensure that the actuaries were properly instructed and understood the assumed contractual terms and legislative framework of the proposed systems of insurance. The actuaries' task was then to make numerous detailed assumptions within this framework to evaluate the expected utilization rates and associated costs for each individual coverage. This required evaluation and selection of expected interest rates, accident rates, health care costs and other factors, in order to estimate the cost of the proposed products. Then, on the basis of a comparison of the estimated costs of the proposed systems of insurance and the current system, an estimated increase or decrease in average premium level was calculated.

- Exhibit 5.1, at 1-4, 6-8
- Oakden, Transcript, at 206-11

8.3 Most of these numerous detailed assumptions do not materially effect the final estimate of premium. The Board will address only those assumptions it has found to be material.

- Exhibit 5.1, at 8
- Oakden, Transcript, at 210

8.4 At the outset, the Board notes that all of the estimates, including those of the Board, are based on some level of uncertainty. The following limitations should be noted.

1. Limitations of the Cost Estimates

(a) Assumptions

8.5 The Reference provided only a broad outline of the terms of the three proposed systems, rather than providing either proposed policy wordings or proposed draft legislation. This meant that the terms of the Reference were not sufficiently particular to make it possible for the Board to fulfil its mandate without making a great number of very important assumptions as to the exact terms that might be incorporated in the proposed systems of insurance, should they in fact ever be enacted. At the first pre-hearing conference the potential for a great variation in costing estimates, depending upon what assumptions were made, was discussed by the parties. The Board directed Board Counsel to prepare a common set of assumptions for the use of all parties in preparation of cost estimates.

8.6 A meeting of all parties was held prior to the second pre-hearing conference to attempt to identify the ambiguities in the Reference and provide guidance with respect to the assumptions to be made. As a result of this meeting, certain detailed assumptions, as set out in a letter from Board Counsel to Tillinghast dated March 28, 1989 (Exhibit 5.3.2), were provided to all parties in an attempt to ensure that all cost estimates proceeded on the same basis. If the Government disagrees with the assumptions which the Board had no alternative but to adopt, then it follows that any different assumptions would affect the pricing of the product. The Board emphasizes that its conclusions as to the costs of the three proposed systems are premised not only on the terms of the Reference, but also upon the assumptions as set out in Exhibit 5.3.2. Any change in these assumptions could have a substantial impact on the cost of each proposal.

8.7 The calculation of premium levels and savings herein apply only to the specific proposals before the Board. The calculated premium levels are sensitive to varying assumptions and a relatively insignificant change to one of the proposals could render the cost estimates invalid. Any proposed variations on the proposals set out in the Reference must be costed separately and it cannot be assumed that the premium levels for any of the proposals bear any relationship to premium levels of any proposed variation.

8.8 It goes without saying that attempting to predict the future is fraught with difficulties, and any attempt to cost a new system of insurance, of necessity, involves just such an exercise. The cost estimates, which provided the basis for the Board's findings, were based upon, among other factors, discounted values of predicted future medical costs, estimates of future accident frequencies, future utilization rates, future wage distributions, future interest rates and other factors of this nature which could not be predicted with any great certainty, and these factors of course add further uncertainty to the cost estimates. The product is new and the estimates suffer from the fact that no relevant data experience is available in this Province.

(b) Appropriateness of Statistics

8.9 The Board's analysis was further complicated by difficulties in obtaining appropriate statistics. American statistics are available, by way of the AIRAC study, which are of assistance in estimating the impact of threshold systems in the U.S. The AIRAC data are data compiled by the All-Industry Research Advisory Council, an insurance industry coalition group in the United States. This group compiled what are known as the AIRAC data from closed claim files of insurers in the U.S. Each closed claim file was examined by a claims examiner who then completed a form setting out data from the file as well as the claims examiner's judgment with respect to such matters as whether or not the claim would have met any applicable threshold for suit. No comparable Ontario or Canadian statistics were available for this Hearing.

- Exhibit 21.3, Tab C; Bryan, Transcript, at 2742, 2880
- Exhibit 21.21
- Miller, Transcript, at 2086
- Oakden, Transcript, at 7114

8.10 With respect to the two proposed threshold systems, one might expect that a certain degree of comfort could be taken from U.S. experience and U.S. historical data, and particularly from the AIRAC study. The wording of Option 1 is almost identical to the wording of the threshold currently in effect in the State of Michigan, and that of Option 2 is identical to that in effect in the State of New York.

- Reiersen, Transcript, at 766; Exhibits 6.3, 6.4
- Gromek, Transcript, at 1412; Exhibits 7.5, 7.6

8.11 The Board, however, advises caution before putting too great an emphasis upon the U.S. experience and statistical data. One must remember that there are major differences between the U.S. and Ontario experiences. In the first place, the U.S. threshold systems were introduced in the 1970s into a system which had virtually no first party automobile insurance benefits and no universal medical care. Accident victims with even the most minor injuries were forced to resort to the tort system to recover their medical expenses. In contrast, Ontario currently has no fault benefits (those provided in Section B of the SPF 1 as well as the medical benefits provided by OHIP) that are already as good as or better than those provided by some existing U.S. no fault systems. As a result it may very well be that, at present, an Ontario resident who suffered from a minor injury would be sufficiently satisfied by the Section B Accident Benefits and OHIP to forego a tort remedy, but a similarly injured American (pre-no fault) might have felt obliged to commence a tort action to recover medical costs and out-of-pocket expenses. The weight of the evidence before the Board clearly indicates that the introduction of no fault systems into the United States was intended to achieve a level of benefit payment which in large measure already exists through the broad Ontario reparation system.

- Reiersen, Transcript, at 648, 758-65; Exhibit 7.9
- Creamer, Transcript, at 1263
- Merin, Transcript, at 3383-84, 3404

8.12 Further, it is the view of the Board that the environment and traditions in this Province are different from those in New York and Michigan. For example, our court systems and traditions make us less litigious than our American neighbours. One very significant difference is that, in Ontario, the court cost system increases the risks to the parties, and tends to discourage plaintiffs with marginal cases.

8.13 The American experience is of even less assistance in evaluating the proposed choice option. Although there are insurance systems in place in Kentucky and New Jersey in which consumers were given some choices between products, the choice proposal before the Board is entirely different from those systems.

8.14 In the Kentucky plan, consumers are given the choice between a straight tort system with optional no fault benefits, or a threshold tort system (with a threshold essentially of $1,000 in medical expenses) with fixed no fault benefits.

- Watts, Transcript, at 3205

8.15 In New Jersey, consumers are given a choice as to whether or not they wish to be subject to a verbal tort threshold. A facility has been set up in the State to allow for transfer payments between insurers to compensate for the differing risks between the two pools of drivers. Under either choice, insureds have the same no fault benefits.

- Merin, Transcript, at 3390-91

8.16 The choice option before the Board is entirely different from either the Kentucky or New Jersey plan. The choice proposal in the Reference purports to give the consumer the choice between no fault and tort insurance. However choice "tort" is a misnomer. The choice tort option lacks the essential ingredient of a tort system, that is, the placing of the burden of the cost of damage upon the at fault party. The choice tort option is first party, rather than third party, insurance and is a form of no fault insurance in which the insured's recovery is limited by the insured's degree of contributory negligence, but no damages are payable by the at fault party. Under either option of choice the insured's right to sue the at fault party in tort is entirely taken away. The choice option provides the insured with a choice between two different first party systems. It is entirely unique and nothing remotely similar has been tried anywhere else in the world.

- Exhibit 21.3, at 1; Bryan, Transcript, at 2940-41

(c) Prices and Dislocation

8.17 The setting of prices is essentially accomplished through two steps. The first is the determination of the total amount of premium to be collected. The second step is to determine, through a classification scheme, from which insureds the premium will be collected. The intent is that enough revenue can be collected to equal the total revenue under step one.

8.18 Once new estimated average premium levels have been established, classification and rating decisions affect the price that individual insureds pay. The Board cannot express too strongly that the average price is meaningless to the individual as average price changes may or may not be experienced by individuals. They are a standard only and the actual premium an insured pays will be higher or lower than the average. As well, dislocation effects arising from class plan uniformity; abolition of rating on age, sex, marital status, family status and handicap; and the continued price freeze are not addressed in the estimated average prices for the three proposals. In this regard the Board notes that irrespective of what reform package the Government might establish, dislocation is going to occur and in some individual cases it will be severe.

(d) Company Circumstances

8.19 It should also be noted that, not only will the actual cost changes vary from one individual policyholder to another, they will also vary from one insurance company to another. A particular insurance company may save more or less on the average than forecast by the actuarial calculations depending on a number of factors, including, for instance, the proportion of high and low risk drivers in a particular company's book of business.

(e) Regulation

8.20 Although the three options are described as "systems of insurance", they are not that. The Board has been provided with no guidance in the Reference as to the rating system to be utilized with the proposals, or the type of regulatory regime envisaged. While it might be anticipated that matters would proceed much as they have in the past if one of the two thresholds were introduced, choice is so radically different from the system now in place that one must anticipate rather substantial regulatory changes. It is hard to see how choice could be made to work without detailed changes, at least in the manner of rating risks. Inevitably any such changes would affect the costing of the systems.

- Miller, Transcript, at 1898-99

(f) Other Costs

8.21 Not all aspects of the potential costs of the proposed systems could be quantified. This issue is fully developed in Chapters 4, 5 and 6. The Board heard evidence, particularly from other jurisdictions, that the proposed systems would likely impose additional administrative costs arising from such matters as litigation to interpret the threshold, administrative burdens arising from the two parallel systems of insurance involved in the choice proposal, start up costs, alternative dispute resolution costs, etc. These costs have not been quantified and included in the actuarial calculations, and therefore, depending on the magnitude of these factors, the estimated costs herein will be understated.

- Tillinghast, Transcript, at 82-87

8.22 It is extremely important that the Government be aware that any cost savings forecast by this Report arise almost entirely from a reduction in benefits payable to injured claimants, rather than as a result of any increase in efficiency of the proposed systems of insurance compared with the existing system. No fault automobile insurance does not result in an automatic decrease in insurance premiums. The evidence before the Board is to the contrary. No fault insurance can produce an increase in insurance costs. For instance, insurance premiums in Quebec, a pure no fault province, are as high as those in Ontario, notwithstanding the fact that the benefits available under the Quebec system, at least to not at fault claimants, are substantially less than the recovery available to tort claimants in Ontario.

- Exhibit 12.11
- Oakden, Transcript, at 57, 66-75
- Reiersen, Transcript, at 642, 645-46
- Elms, Transcript, at 2628
- Creamer, Transcript, at 1264
- Bryan, Transcript, at 2766-68
- Lehmann, Transcript, at 5047-48

(g) Future Price Increases

8.23 Finally, any percentage savings due to the introduction of no fault are one-time savings only. That is, any potential premium decreases associated with the introduction of no fault will, over the years, be subject to future price increases. In short, potential no fault associated price reductions will not be permanent. After the implementation of any new system of insurance, loss costs, and hence premiums, will continue to rise at levels at least equal to those that would exist under the current system, all other things being equal.

- Bryan, Transcript, at 2776
- Watts, Transcript, at 3228-29
- Hunter, Transcript, at 6812
- Tillinghast, Transcript, at 7172-73

2. The Conclusions of the Actuaries

8.24 In addition to the cost estimate produced by Tillinghast, the Industry Coalition commissioned a parallel study by The Wyatt Company. Actuarial evidence was also produced by Allstate, State Farm, and by Mr. Hunter on behalf of the CAC. However only the Tillinghast and Wyatt reports were complete cost analyses of the three options based on the terms of the Reference and Exhibit 5.3.2. Tillinghast made numerous detailed assumptions in its costs estimates, while Wyatt treated the costing in a much more global manner.

- Exhibit 5.1 (Tillinghast)
- Exhibit 21.2 (Wyatt)
- Exhibit 21.6 (Allstate)
- Exhibit 28.3 (State Farm)
- Exhibit 30.2 (CAC)
- Oakden, Transcript, at 210 ff.
- Miller, Transcript, at 1364 ff.

8.25 Tillinghast's initial estimated cost changes for each of the proposals were as follows: Option 1: -14.0%; Option 2: -4.9%; and for Option 3, choice tort: +2.5%; and choice no fault: -33.6%.

- Exhibits 5.1, 5.1(b)

8.26 After all the evidence had been examined, Tillinghast recalculated its figures, based on further information obtained during the course of the Hearing. Wyatt, at the end of the Hearing, saw no reason to change its original estimates. The final cost estimates for each proposed system, as calculated by Tillinghast and Wyatt, are shown in the chart below. Estimates based on less detailed reviews by the other actuaries testifying are included for comparison purposes.

Estimated Change from Benchmark Rate
(All Coverages Combined)

	Option 1	Option 2	Option 3 - Choice	
			Tort	No Fault
Tillinghast	-8.0%	-3.7%	+2.5%	-30.0
Wyatt	+0.4%	+4.4%	+0.1%	-22.9
Allstate	-13.4%*	-8.4%*	NA	NA
State Farm	-3.7%	-1.3%	0.0%	-13.6%
Hunter(CAC)	-5.0%	0.0%	0.0%	-25.0%

* These are maximum rather than expected cost changes according to Allstate (Exhibit 21.6, at 4).

- Exhibits 5.1, 5.1(b), 4.2.2 (Tillinghast)
- Exhibit 21.2 (Wyatt)
- Exhibit 21.6 (Allstate)
- Exhibit 28.3 (State Farm)
- Exhibit 30.2 (CAC)
- Trudeau, Transcript, at 7108
- Miller, Transcript, at 7080-81

B. DATA

8.27 The Tillinghast and Wyatt actuarial reports relied on a variety of data sources. The main data sources included:

- The Report of Inquiry into Motor Vehicle Accident Compensation in Ontario, The Honourable Mr. Justice

Osborne, and the underlying data collected for the survey of Appendix III, Volume II, (Exhibit 13.6)

- Ontario Road Safety Annual Report, 1987, Ministry of Transportation (Exhibit 13.8)
- Ontario Income Tax Statistics from Revenue Canada
- Régie de l'assurance automobile du Québec Fiscal Accident Year Disability Pattern
- Census Canada 1986
- IBC Calendar/Accident year experience report (AIX33)
- IBC 1984 Calendar and Accident year incurred losses & external loss adjustment expenses by size of loss
- 1987 Direct expense report for Ontario automobile
- IBC Statistical Plan data
- Compensation for Automobile Injuries in the United States, AIRAC, 1989, (Exhibit 21.3, Tab C), (Wyatt only)
- Decision I-88-1D regarding rates for private passenger automobiles
- Statistics Canada
    - Exhibit 5.1, at 2
    - Exhibit 21.2.2, at I-3

8.28 It should be noted that, for the most part, the authors of the data set out above were not called upon to testify, and the Board, because of time constraints, did not go behind the data.

8.29 The major differences between the data sources used by Tillinghast and Wyatt were that Wyatt used older data from the Régie de l'assurance automobile du Québec (Régie) whereas Tillinghast used up-to-date data, and Wyatt made use of the AIRAC data which was not available to Tillinghast. In the Board's opinion, the use of the older Régie data by Wyatt does not significantly affect Wyatt's result.

- Oakden, Transcript, at 170, 172, 245, 255, 257, 314
- Miller, Transcript, at 1551, 1553, 1554, 1569, 1659

8.30 The Board has reservations about applying the AIRAC data to Ontario directly, without the exercise of informed judgment, for reasons set out above in paragraphs 8.11 and 8.12. In addition, caution must be exercised in the use of the AIRAC data because of the subjective nature of some of the data, in particular the data as to number of claims meeting the threshold based on the PIP closed claims study.

- Groot, Transcript, at 2117-19
- Oakden, Transcript, at 7115

C. BENCHMARK RATE

8.31 The mandate of the Board was to estimate average prices for each of the proposals relative to the benchmark rate.

8.32 The benchmark rate for a coverage is an average rate for all classes of risks (i.e., an average over all driver characteristics, limits, deductibles, territories, etc.). Both actuarial reports utilized the benchmark, or average rate, in the calculation of the cost changes associated with each of the proposals. This cost change may or may not apply to any given individual insured, depending on the rating method used and coverages purchased. The average benchmark premium is 7.6% higher than the average premium prior to June 1, 1989 and approximates the expected average premium post June 1, 1989. The expected average premium post June 1, 1989 is $756.00. Since not all drivers purchase collision and comprehensive coverages (78.3 and 91.8 percent respectively), whereas all drivers must purchase third party liability and accident benefit coverages, the average premium is less than the total benchmark rate, which is $796.00.

8.33 Wyatt, in addition, calculated the estimated cost savings of the three systems based on its interpretation of current adequacy level rates, rather than the benchmark rate. Wyatt, having reviewed actual 1988 experience (not available to the Board when it rendered Decision I-88-1D) confirmed that it agreed with the Mercer indicated actuarial inadequacy of approximately 35% for the period March 1989 to March 1990, based on average premium. Wyatt's adequacy calculations are not trended through 1990. The rate inadequacy assumed by Wyatt varies significantly by coverage. Third party liability and accident benefits coverages are indicated as significantly inadequately priced, whereas collision and comprehensive coverages are priced at close to adequacy. As the Reference required comparison to the benchmark rate, the Board utilized only comparisons to the benchmark rate in its findings. In Chapter 6 the Board deals with rate inadequacy. With the level of rate inadequacy, as explored at length in this Hearing, it is clear that reference to a benchmark serves the purpose only of estimating changes in percentages for comparisons.

- Exhibit 21.2.2, at I-2
- Miller, Transcript, at 1548-49, 1556, 1564, 1650

D. EFFECTIVE PERIOD

8.34 The proposed cost changes relate to the benchmark rate and hence to the effective period for this rate. The effective period is June 1, 1989 through December 31, 1989. There was evidence before the Board that current loss cost trends (for all coverages) are in the vicinity of 10% per year. If the Government is unable to legislate and implement product reform within its target time frame, premiums will, of course, have to be adjusted to reflect this annual loss cost trend. The Board is compelled to note, as it has in previous Decisions, that inadequate or delayed rate increases will cause some companies to cease writing new business and the size of the Facility Association percentage to increase.

- Oakden, Transcript, at 48-49

E. PROFIT

8.35 Both the Tillinghast and Wyatt reports used discounted loss costs to estimate the new premium and relied on the underwriting margins, as provided in the Board Decision dated November 22, 1988 (Decision I-88-1C) on profitability standards, without further study. The historic claim payout pattern is an inherent factor underlying the underwriting margin (which derives from the 12.5% return on equity) in Decision I-88-1C. Under the proposals, the payout pattern should be different and therefore the appropriate underwriting margin should be different. If the payout pattern is shorter than at present, then maintenance of the same margin will cause the overall savings to be less than otherwise stated. Alternatively, if the payout pattern is longer than it currently is, then maintenance of the same margin will cause the indicated reductions to be understated.

8.36 The methodology adopted by the Board in the earlier hearing involves a static financial model. Inherent in the costing of each of the options is an implied profit which is likely different from the profit set by the Board in the Industry-Wide Hearing. This inherent limitation in the calculations does not necessarily imply that the Board amends its prior decision regarding the appropriate profit level. However, depending on what new product is implemented, and the method of rate regulation, the profitability determination of the Board will require reconsideration.

- Tillinghast, Transcript, at 512, 585-86, 589, 612-15

F. SELECTION BETWEEN CHOICE OPTIONS

8.37 If the assumption is made that the population of motorists selecting choice no fault will be different from the population selecting the choice tort option, this will affect the relative premiums of the two systems as well as the average premium of the choice option as a whole.

- Tillinghast, Transcript, at 196, 380, 913
- Miller, Transcript, at 1970, 1987

8.38 Tillinghast assumed that there would be non-random selection under choice in that lower income insureds would be more likely to select the no fault option on the assumption that they would be the most price-conscious shoppers and on the ground that they would be the most adequately compensated by the no fault lost income benefits. This assumption caused the estimated no fault benefits premium to vary for the three proposed systems despite provision of the same benefit package.

- Oakden, Transcript, at 190 ff.; Exhibit 5.1(b), at Exhibit IV, Sheets 13 and 16

8.39 Wyatt assumed that the selection would be random, that is, that the two pools would include an equivalent cross-section of the overall market.

- Miller, Transcript, at 1620, 1853-55; Exhibit 21.2.2, at IV-12

8.40 In the Board's opinion, under choice, the distribution of population between the two choices would depend directly upon the rating categories and the manner in which the product options were rated and priced, and could involve factors considerably more complex than those suggested by Tillinghast. This issue if fully discussed in Chapter 6.

8.41 The weight of the evidence before the Board indicated quite clearly that there would be a preference on the part of some companies and on the part of some consumers to select the no fault option under choice. The Board therefore rejects Wyatt's evidence that there would be random selection under the choice option. The Board finds that, in all likelihood, the population of drivers selecting choice tort will differ, perhaps significantly, from the population selecting choice no fault. It is possible that this will have the result that either one segment of the driving population will end up subsidizing the other, or the price of one or other of the options will be forced so far out of line as to render the choice meaningless and in effect drive one or other of the choice options out of the marketplace. Although the Board does not agree that selection will occur in as simplistic a fashion as suggested by Tillinghast, the precise manner of the selection could not be determined, even if more precise information, such as the manner in which rating and classification would be determined, were available. The Board therefore, of necessity, will use the Tillinghast estimate of selection in estimating the cost of the choice proposals.

- Oakden, Transcript, at 196-98
- Carr, Transcript, at 5808-23, 5834-43, 6052-59; Exhibit 19.3

G. ACCIDENT FREQUENCY

8.42 Both the Tillinghast and Wyatt reports proceeded on the assumption that there would be no increase in accident frequency, with the exception of the inclusion in the Wyatt report of an increase in utilization of medical and rehabilitation benefits, which may be partially attributable to increased accident frequency.

- Miller, Transcript, at 1689-96
- Tillinghast, Transcript, at 7014-15

8.43 The Board has dealt with this issue in detail in Chapter 5. For reasons set out in that Chapter, the Board is of the opinion that the proposed systems, and in particular the choice system, will result in increased accident frequency. This will result in an increase in premiums beyond those set out in the actuarial reports and a corresponding reduction in the predicted savings nearly in direct proportion to the increase in accident frequency. For instance, a 10% increase in accident frequency will result in close to a 10% increase in costs and premiums, and a 10 percentage point reduction in savings, all other things being equal. The Board is unable to quantify the amount of the increase in accident frequency. For illustrative purposes the Board has looked at the impact of 0%, 5% and 10% increases in accident frequency (see paragraph 8.96). The Board notes, however, that the increase in accident frequency will not apply equally across all systems.

H. UTILIZATION

8.44 In Chapter 4 the Board finds that it is essential that any new system of automobile insurance incorporate dispute resolution mechanisms for no fault benefits and sanctions against slow payment by the insurer in order to facilitate the delivery of no fault benefits. If such measures are introduced, they, by themselves, will cause an increase in the utilization rates of no fault benefits.

8.45 As well, there was evidence that other factors will increase the utilization rates of no fault benefits under the three proposed systems of insurance compared with the utilization rates under the existing system of insurance.

- Tillinghast, Transcript, at 221-35
- R. Rogers, Transcript, at 2274
- Elms, Transcript, at 2705-08
- Bryan, Transcript, at 2830
- Corey, Transcript, at 3978
- Lehmann, Transcript, at 5046-47, 5068-74
- Priest, Transcript, at 6343

8.46 The accident benefits available under all of the referred systems, except for choice tort, are substantially enhanced from the present benefits, particularly in the case of medical and rehabilitation benefits. This by itself will cause an increase in utilization, particularly as the public becomes more aware of the existence of these enhanced benefits. Further, these benefits are sufficiently substantial to be worth litigating and claimants will be less likely than now to accept a refusal from an insurer without a fight.

8.47 Although the accident benefits under choice no fault are identical to those proposed under the two threshold systems, there is likely to be a greater increase in utilization of these benefits under choice no fault because the claimant will not have the alternative of claiming indemnity from the tortfeasor for any benefits refused by the first party insurer.

8.48 The same increased utilization would, of course, occur in a pure no fault environment.

8.49 It was suggested in evidence that Option 1 be amended to exclude all but "permanent" injuries to make the threshold considerably more difficult to meet. If this were to take place, an increase in the utilization of accident benefits similar to that under pure no fault would be certain. It stands to reason that, the greater the restriction on tort remedies, the greater will be the utilization of the no fault remedies.

- Oakden, Transcript, at 341-44
- Miller, Transcript, at 7061-63

1. Medical and Rehabilitation Benefits

8.50 Both the Tillinghast and Wyatt reports reflect increased utilization of certain benefits, although at different rates. Tillinghast included a 25% increase in utilization for medical and rehabilitation benefits. Wyatt assumed that all current costs would remain, and that there would be certain additional costs relating to vocational rehabilitation, home renovations and long term care. Accordingly, for example, Wyatt took the conclusion in the Osborne Inquiry Report that 6.5% of medical and rehabilitation claimants will invoke an extra expense of $4,000 for vocational rehabilitation but, doubled that proportion to 13%. In addition, Wyatt increased the underlying frequency by 30%. This appears to be an increase to the underlying accident frequency, but Wyatt was unable to be precise.

- Oakden, Transcript, at 221, 7105
- Miller, Transcript, at 1586-89, 1688-95

8.51 State Farm expressed concern that both Tillinghast and Wyatt had substantially underestimated the expected utilization increase. It felt that the availability of the enhanced benefits would encourage accident victims to seek home care or care in private institutions not covered by OHIP. State Farm concluded, based on its U.S. experience, that utilization of medical and rehabilitation benefits would increase by 40%.

- Lehmann, Transcript, at 5046-47; Exhibits 28.3, 29.4, 4.20.4

8.52 The Board finds that the proposed systems will in fact result in substantially increased utilization of medical, rehabilitation and long term care benefits. Many injured parties today fail to claim medical and rehabilitation benefits or accept a refusal by an insurer without bringing suit. The base of persons claiming medical and rehabilitation benefits in a no fault environment will substantially increase. This is a reflection of the fact that claimants will no longer forego medical and rehabilitation benefits under the proposed systems. Adjustments for increased utilization as more people become aware of the increased benefits will have to be made.

8.53 In the Board's opinion the Tillinghast estimate of increased utilization is too low, particularly if, as the Board recommends elsewhere in this Report, the delivery system for no fault benefits is improved by means of an alternative dispute resolution mechanism and sanctions for late payment. Therefore the Board has decided to double the Tillinghast figure and select a factor of 50% to reflect the combined increased utilization for the two threshold proposals. Further, for choice no fault, the Board finds that there will be an even greater increased utilization since claimants will have no recourse to tort. This will be somewhat tempered by the lack of availability of rehabilitation services, in the short term at least, and the Board has selected an increased utilization factor of 75% under choice no fault. As indicated above, the Board feels that utilization may increase beyond this level with time, as the public becomes aware of the availability of these benefits and treatment facilities expand. However this may be offset by a broadening of the coverage provided by OHIP as suggested in the ARCH evidence. In the long term it is difficult to predict what the ultimate trend will be.

- ARCH, Final Submission, at 12-13

2. Disability Income Benefits

8.54 Tillinghast included a 25% increase in utilization for disability income benefits for employed persons. Wyatt included a 20% increased utilization factor for disability income benefits for all classes of beneficiaries, employed, deemed employed, students, etc.

- Oakden, Transcript, at 222
- Miller, Transcript, at 2030

8.55 For reasons set out above, the Board finds that there will be an increase in the utilization of disability income benefits. However, unlike medical and rehabilitation coverage, disability income benefits do not apply equally to all claimants. The Board therefore has decided to apply a 25% increase (the Tillinghast rate) for all classes of beneficiaries (the Wyatt base), other than those previously not covered for the threshold proposals, and a 35% increase for choice no fault since claimants will have no recourse to tort.

3. Unpaid Housekeeper Benefits

8.56 Wyatt assumed that the number of unpaid housekeeper claimants would be the same as the number of wage earner claimants. Tillinghast initially estimated the number of claimants to be equal to the number of non-wage earning claimants. In a subsequent undertaking, Tillinghast recalculated its figures on the basis that the number of claimants was equal to the number of non-wage earners plus the number of wage earners. The Board finds that these estimates are too high because some eligible claimants will not in fact make a small claim. The Board therefore finds a proper figure to be 75% of the number of wage earners.

- Oakden, Transcript, at 362-67; Exhibit 4.2.5
- Miller, Transcript, at 1589-92, 1724-33

I. RESIDUAL BODILY INJURY

8.57 In any no fault system, even in a pure no fault system, provision must be made for liability coverage for accidents involving claimants outside the system. For instance, in Quebec, which has a comprehensive pure no fault system applying to all vehicles in the Province, all vehicle owners are required to maintain statutory minimum liability insurance to cover their vehicles while outside of the Province of Quebec. This liability coverage, which affords coverage for the cases not covered by no fault, was called in this Hearing "residual bodily injury coverage".

8.58 In the costing of the options, even in the case of choice no fault, the residual bodily injury coverage represents a substantial portion of the premium, as the Reference contemplates that commercial and public vehicles and motorcycles would be outside the coverage afforded by the proposals and would retain full tort rights. In the context of the Reference, then, residual bodily injury coverage includes coverage for claimants outside the proposed systems of insurance, such as commercial and public vehicles, motorcycles, out-of-province vehicles, out-of-province accidents, etc.

8.59 Aside from the difficulties associated with the actuarial estimation of the proportion of vehicles not covered by the proposed systems, this topic is complicated by the fact that the Reference itself is lacking in sufficient detail for the Board to be satisfied as to what claimants were or were not intended to be covered by the new proposed systems. For instance, under choice would pedestrians or cyclists struck by a motor vehicle have primary access to their own insurance policy or to that of the striking vehicle? If pedestrians or cyclists had no policy of their own, would their recourse be against the no fault provisions of the striking vehicle's policy or against its third party liability provisions, or both? The Wyatt report sets out a table of its assumptions as to what claimants are not covered. However, without more detail as to the form that policies or legislation might ultimately take, the Board finds it impossible to state with any confidence the extent to which these assumptions are correct. Nevertheless, the Board must come to some sort of conclusion with respect to this matter.

- Miller, Transcript, at 1592-98, 1736

8.60 In order to estimate the proportion of vehicles covered under each proposal, Wyatt outlined the various coverage situations for BI, such as third party out-of-province accidents, pedestrian/cyclist accidents, and passenger injuries. Wyatt then estimated the proportion of loss costs associated with each situation. Mr. Miller testified that the proportions were based on judgments, with reference to the Osborne Inquiry Report and Quebec experience. For out-of-province accidents, the Wyatt figure at 2.5% of costs was double the 1.1% of accidents cited in the Osborne Inquiry Report, implying that Wyatt had assumed that the severity of out-of-province accidents was double the severity of in-province accidents. Similarly, Wyatt's 15% of loss costs for pedestrian/cyclist accidents compares to 8.7% of claimants in this category according to the Osborne Inquiry Report, another doubling of the severity. Wyatt also assumed that non-private passenger vehicles account for 15% of the loss costs versus 11% of claimants per the Osborne Inquiry Report. In testimony, Wyatt supported the severity assumptions as reflecting the greater injury to pedestrians/cyclists/motorcyclists when in an accident with a car, and the greater injury to passengers in a car when in an accident with a truck. These assumptions produce a total of 20% non-covered loss costs for the threshold systems and 27% for choice. These figures compare to the 12% (later revised to 13%) figure based on vehicle/accident counts, used by Tillinghast for all three options.

- Oakden, Transcript, at 444
- Miller, Transcript, at 1737; Exhibit 21.2.2, at IV-1, 8

8.61 The Board finds that it is more appropriate to utilize the proportion of loss costs associated with non-covered vehicles in the calculation of the estimated price changes. However, it does not agree that the Wyatt selections are appropriate as presented because of the judgmental doubling of severities in several cases. The Board finds that the appropriate figure lies between the Tillinghast estimate based on number of vehicles and the Wyatt loss cost estimates. Therefore, the Board selects 16% for the threshold options and 20% for choice as the proportion of loss costs not covered.

J. INTEREST RATE

8.62 Both Tillinghast and Wyatt assumed an 8% interest rate. The impact of the interest rate on the calculation of the costing of the alternatives is small and the Board finds an 8% interest rate to be appropriate.

- Exhibit 5.1, at 8; Trudeau, Transcript, at 212
- Exhibit 21.2.2, at I-2

K. INDEXATION OF BENEFITS

8.63 Tillinghast utilized a 5% rate of inflation as the indexation rate whereas Wyatt utilized 5.5%. The 0.5% difference in rate produced a 0.5% change in savings. The results of the calculations are not materially sensitive to this factor. The Board has chosen a rate of 5%.

- Oakden, Transcript, at 258; Exhibit 5.1, at 8
- Miller, Transcript, at 1667; Exhibit 21.2.2, at III-1

L. OHIP

8.64 OHIP currently pays for most medical costs of Ontario residents. Under the OHIP subrogation agreement, OHIP is reimbursed by auto insurers for costs related to auto accidents at a rate of 2.4% of the third party liability premium. This sum amounted to approximately $46,000,000 in 1988. Most insurers are part of this agreement. Tillinghast assumed that OHIP would continue to be reimbursed at the 2.4% level under the proposed alternatives. This would result in fewer dollars being transferred to OHIP since the proposals anticipate that the third party liability premium would decrease. Tillinghast re-evaluated the change in its results assuming constant OHIP dollars: 0.7% for Option 1; 0.5% for Option 2; and for Option 3, 0.1% for choice tort and 1.1% for choice no fault. The Wyatt original calculations assumed a constant dollar value for OHIP.

- Trudeau, Transcript, at 92-97
- Oakden, Transcript, at 7104
- Exhibit 4.1.1
- Miller, Transcript, at 1582-85, 1734

8.65 The Reference itself was silent as to how the proposed insurance systems would interact with OHIP. Logically, choice should result in the abolition of the right of suit for damages arising from an automobile accident and this would have the result, if taken at face value, of removing OHIP's right of subrogation altogether, with a resulting shifting of the burden of automobile accident costs from the automobile insurance system to OHIP.

- Trudeau, Transcript, at 96
- Oakden, Transcript, at 7104
- Exhibit 4.1.1

8.66 The Board notes that if any of these proposals is implemented it will give rise to a significant public policy decision as to whether the costs of auto reparations should be identified and attributed to the automobile compensation system rather than the general health care scheme.

8.67 For purposes of this costing, the Board has based its calculations on the premise that OHIP will continue to receive the current dollar value of approximately $46,000,000 per annum from the auto insurance premiums paid in this Province.

M. EXCESS ECONOMIC LOSS

8.68 In calculating excess economic loss, Tillinghast initially assumed that 80% of gross wages would be accepted as full recovery for all claimants. Wyatt assumed that 100% of gross wage loss would be sought by all claimants. Tillinghast subsequently amended its assumption for those earning in excess of $450 per week to 100%.

- Trudeau, Transcript, at 7107; Exhibit 4.1.2
- Miller, Transcript, at 1952

8.69 The Board finds that it is reasonable to assume that all claimants who meet the threshold (and therefore will likely commence an action for their non-pecuniary damages) will include a claim for their excess economic loss and recover 100% of their economic loss. Of those claimants who do not meet the threshold, those earning less than $450 per week would have a small enough excess economic claim that few would bring suit to recover it. Of the remaining claimants, that is, those who do not meet the threshold but earn more than $450 per week, some would have a sufficiently large claim to justify a suit but many would not.

8.70 The Board therefore has assumed that all claimants who meet the threshold will recover 100% of their economic loss. The Board further assumes that of the claimants who do not meet the threshold, half of those earning over $450 per week will recover 100% of their economic loss and the remainder will recover, 80% of their gross wage to a maximum of $450; all of those earning under $450 will recover 80% of their economic loss.

N. EFFECTIVENESS OF THE THRESHOLD

8.71 One of the major points of departure of Tillinghast and Wyatt, and the most material assumption to the estimation of average prices of the two threshold systems, is the method of calculating the proportion of claimants who fail to meet the threshold.

8.72 In estimating the value of Option 1, Tillinghast referenced the 1987 Ontario Road Safety Report to match the kind of accidents considered there as "major" with the threshold definition. Based on this analysis Tillinghast concluded that Option 1 would allow 9% of the current BI cases to be pursued for non-pecuniary compensation.

- Exhibit 13.8
- Oakden, Transcript, at 327-41
- Miller, Transcript, at 1574-75

8.73 Tillinghast concluded that its estimate of the value of Option 1 was supported by the Régie disability table which indicated that its estimate of the value of Option 1 corresponded to a one year disability. It also cited the Osborne Inquiry Report wherein a more restrictive threshold proposed was calculated by the IBC to allow 8% of current BI claims to be pursued.

- Oakden, Transcript, at 340-46
- Exhibit 5.1, at Exhibit VI, Sheet 2
- Exhibit 21.10, at 14-15

8.74 At the conclusion of the Hearing, Tillinghast revised its opinion, based upon all the evidence in the Hearing, to conclude that Option 1 would permit 15% of claims to qualify for tort. It reasoned that some less serious injuries would get through the threshold than it originally believed, but felt that the AIRAC data used by Wyatt was too subjective to be relied upon.

- Oakden, Transcript, at 7103, 7107

8.75 Tillinghast used a different methodology to estimate the effect of Option 2. Tillinghast used the Osborne survey by type of injury and size of loss, and concluded that Option 2 would allow all claimants with claims under $10,000 (in 1986 dollars), or 33% of current BI cases, to be pursued in tort. This was based on its estimation that a fracture would be the type of injury which would most easily pierce the threshold. Reviewing the Osborne survey by size of loss showed that fractures and associated injuries had BI claim values of about $10,000.

- Oakden, Transcript, at 146-49
- Exhibit 5.1, at Exhibit II, Sheet 16

8.76 Tillinghast further assumed that all claim expenses are proportional to the size of the claim. These assumptions were then applied to the IBC bodily injury size of loss distribution for accident year 1984 to estimate the percentage of loss dollars that would be removed by the threshold. In making this calculation it was further assumed that the losses remaining in tort are the largest ones.

- Oakden, Transcript, at 7109

8.77 Wyatt used the 1989 AIRAC report to estimate the values of both thresholds. The report included a study of closed accident benefits claims for various U.S. no fault states. Each claim was evaluated by a claims adjuster as to whether or not the claimant would be eligible to sue in the particular no fault state. Wyatt utilized these results to conclude that Option 1 would allow 21.7% of current tort claimants to continue to qualify for tort recovery, and that Option 2 would allow 46.7% of current claimants to continue to qualify for tort recovery. Mr. Miller testified that the change in the New York BI frequency based on ISO Fast Track data could be used to corroborate his estimate of Option 2.

- Exhibit 21.3, Tab C
- Miller, Transcript, at 1568-73

8.78 Allstate utilized data included in the AIRAC study to conduct its own analysis. The AIRAC study was based on a country-wide sample of paid injury claims and the information drawn from these claims was organized to explore a number of different questions, not just those relating to the claimants judged by the file reviewers to be eligible to make a tort claim in verbal threshold states. For instance, AIRAC provided 18 categories of types of injury and, by coverage, file reviewers determined into which category the injury underlying the paid claim belonged. Allstate drew upon two types of different data, and compared the results from both, in coming to its conclusions.

8.79 First, Allstate calculated the values of the thresholds by applying a strict definition of the thresholds to the types of injury data for all U.S. tort liability states. It concluded that Option 1 would allow 6.3% of the claimants and 63% of the dollars to pass the threshold. BI costs were estimated to be further reduced by 15% due to the reduction in economic loss sought through the tort system under the enhanced accident benefits. Therefore, the total estimated change in the BI premium for Option 1 was -52% and for liability coverage in total was -37.5%. Allstate stated that this was a maximum savings based on a strict interpretation of the threshold.

8.80 Second, on the basis that Allstate believes that courts would generally be more liberal in applying the thresholds, Allstate considered the determinations by the file reviewers of which Michigan PIP claims would meet the threshold and concluded that over 20% would do so. Using the same underlying data, Mr. Miller arrived at a figure of 21.7% as noted in the paragraph below. Allstate did not agree with that result, and stated that, using the data and Mr. Miller's methodology, the result should be 25.5%. Looking at its two methods of calculating the percentage that will pass the threshold -- predicting what types of injuries in tort states would qualify to pass a threshold and applying professional judgement to determine which claims made in threshold states would qualify to pass -- Allstate preferred the professional judgement methodology. The discrepancy between its conclusion and that of Mr. Miller underlines that the professional judgement methodology is difficult to consistently apply. No proposed premium cost changes were calculated based on this estimate. Allstate's internal data for Michigan indicated that BI claim frequency dropped about 85% subsequent to the introduction of the Michigan threshold.

- Exhibit 21.6; Groot, Transcript, at 2087-90, 2119, 2153, 2268-69

8.81 The Board notes that all the analyses conducted by type of injury indicate that Option 1 would allow 6% to 9% of the claimants to sue in tort, but analyses based on reviews of closed claims by claims adjusters to subjectively identify those who could meet the threshold indicated that about 25% of the claimants could continue tort claims.

8.82 State Farm presented cost change estimates for accident benefits and liability coverage. State Farm stated that its cost estimates were based primarily on its U.S. experience adjusted as much as possible to Ontario, but did not reflect the detailed instructions of Exhibit 5.3.2. Mr. Lehmann expressed concern about the divergence of the various actuarial cost estimates, but did not find the range unreasonable.

- Exhibits 28.3, 29.4; Lehmann, Transcript, at 5041

8.83 Option 1 was estimated to produce a BI cost change of -48%. This estimate was based on the observation of State Farm relative paid pure premiums in Michigan and Illinois from 1971 through 1988. The estimated BI cost change of -43% for Option 2 was judgmentally set at 5% less than for Michigan. These findings are supported by State Farm BI frequencies.

- Exhibits 28.3, 29.4; Lehmann, Transcript, at 5043, 5045, 5062

8.84 These figures can be summarized in tabular form as follows:

Bodily Injury Threshold Penetration Level and Cost Changes*

	Option 1	Option 2
Tillinghast	9%	33%
Wyatt	21.7%	46.7%
Allstate	6.3% (-37%)**	23.7% (-26%)**
State Farm	15-20% (-48%)	25% (-43%)

* Numbers in brackets are cost changes in the BI portion of the premium only, resulting from the penetration levels immediately preceding the brackets.

** Allstate's estimates were maximum rather than expected changes, based on a strict application of the threshold. (Exhibit 21.6, at 4)

8.85 For reasons set out earlier (paragraphs 8.11 and 8.12), the Board has reservations about the applicability of U.S. loss statistics to Ontario, as used by Wyatt. The Board has further concerns with respect to the use of the AIRAC data to calculate the value of the threshold, since the data as to the value of the threshold arises primarily as a result of judgments by insurance claims examiners as to whether a particular injury would or would not meet the threshold.

8.86 The Board prefers the methodology used by Tillinghast, with some modification, with respect to the calculation of Option 1.

8.87 Tillinghast calculated the value of Option 1 using the Ministry of Transportation's 1987 Ontario Road Safety Annual Report (Exhibit 13.8). Tillinghast attempted to match the threshold wording to the injury descriptions provided in the report. The report summarizes accidents by categories: fatal; major; minor; and minimal. The data showed that approximately 600,000 were involved in accidents in 1987 with approximately 122,000 injuries. Tillinghast assumed that those with fatal and major injuries (approximately 10,700 or 8.8%) would meet the threshold, while the remaining minor and minimally injured victims would no longer qualify for suit. Approximately 50,000 people brought bodily injury claims arising out of 1987 accidents.

8.88 In cross-examination it was pointed out that the MTO categorization of injuries was likely based on police reports rather than medical assessment of the injuries. It was also suggested that those with minimal injuries, i.e., those with minor abrasions and bruises, would likely be taken care of by accident benefits and not sue and, therefore, should not have been included in the claimant base of 122,000. Similarly, some in the minor injury category would not sue. Tillinghast agreed that a substantial number of those with minimal injuries will not sue but that many do as evidenced by the total number of bodily injury claims. Tillinghast also stated that some of those in the major injury category may not actually qualify for suit either. There may be too many claims in the claimant base (122,000), thus overestimating the value of the threshold, but the number actually qualifying for suit may be either smaller or larger than assumed.

8.89 The Board finds that there is an inconsistency between the number of injuries (122,000) and the number of BI claims (50,000) even when it is assumed that 50% are at fault (about 25% are likely barred from suit because of total fault). Therefore, although the Board does not agree with the IBC suggestion that all those with minimal injuries will not make claims, it finds that many of those in the minimal injury category do not make BI claims. At the same time the Board recognizes the Tillinghast point that some of those in the major injury category will not make claims. The Board notes that Tillinghast's reasoning underlying the revision in its estimate to 15% is that some of those with minor injuries will qualify for suit.

- Oakden, Transcript, at 7103

8.90 The Board concludes, however, that the number of major injuries not qualifying for suit would be approximately offset by the number of minor injuries qualifying. The Board further concludes that the claimant base should be adjusted to reflect the proportion of minimally injured claimants that would not otherwise have sued. If this number is assumed to be 25% of the minimally injured, then the revised claimant base is approximately 70,000 and, with 10,700 people meeting the threshold, the Board estimates 15% for penetration of Option 1, although for different reasons than Tillinghast.

8.91 The Board also rejects Wyatt's calculation of the penetration level of Option 2 for the same reasons as for Option 1.

8.92 Further support for this finding may be found in the testimony of several American witnesses to the effect that the differences between the Michigan and New York thresholds (Options 1 and 2) were not as great as might be anticipated. Mr. Merin indicated that New Jersey studied both thresholds, initially preferring Michigan because it was thought that the Michigan wording would eliminate more lawsuits. The results of a closed claim study undertaken by New Jersey, unlike the Wyatt conclusion, showed that both thresholds reduced lawsuits and that the number of cases eliminated by the thresholds was similar on a percentage basis.

- Merin, Transcript, at 3438, 3476-77
- Baker, Transcript, at 6659, 6708
- Progressive, Transcript, at 4063
- State Farm, Transcript, at 5049

8.93 Tillinghast's calculation of Option 2 proceeded on a different basis than for Option 1, as explained above. The Board accepts Tillinghast's analysis with respect to Option 2 and estimates that the threshold penetration with respect to Option 2 is 33%.

- Oakden, Transcript, at 174

O. CONCLUSIONS

8.94 The Board has reviewed the Tillinghast and Wyatt reports and all testimony, and evaluated the assumptions therein. The Board finds that these recommendations captured the range of reasonableness of estimated cost changes. The Board agrees with Mr. Hunter that the value of the proposed changes lies between the Tillinghast and Wyatt estimates.

8.95 Applying the Board's findings, as outlined above, results in estimated cost changes for each option as summarized in the table below. As stated in paragraph

8.43, the Board believes that there will be an increase in accident frequency if these proposals are adopted but could not quantify the amount. Thus, considering all factors except for the change in accident frequency arising from the introduction of a no fault system, the Board finds the changes from benchmark rates to be as follows:

Option	**Estimated Change From Benchmark Rate**
Option 1	-6%
Option 2	-0.3
Option 3 - Choice Tort - Choice No Fault	+2.2 -23.1%

8.96 The Board recognizes that the amount of the increased accident frequency is very difficult to estimate. However, what is not in dispute is that some increase in frequency will result. What that increase might be cannot be realistically determined until product reform has been implemented for several years. Thus the projected savings at a 0% increased accident frequency may be too optimistic. The estimated cost changes reflecting changes in accident frequency of +5% and +10% are provided for illustrative purposes only. As noted in paragraph 8.43 any increase in accident frequency will not apply equally across all options.

Estimated Change from Benchmark Rate (All Coverages Combined)				
Increased Accident Frequency	Option 1	Option 2	Option 3 - Choice	
			Tort	No Fault
0%	-6.0%	-0.3%	+ 2.2%	-23.1%
+5%	-2.0	+4.0	+ 6.6	-20.0
+10%	+2.0	+8.3	+11.0	-16.9

9. EXTENSION TO OTHER VEHICLES

A. INTRODUCTION

9.1 The Board was asked in the Reference to consider the feasibility of extending the three proposed systems of privately-delivered automobile insurance to categories other than private passenger automobiles, namely, public vehicles (buses, funeral vehicles, ambulances and taxis and limousines) and commercial vehicles (vehicles used primarily to transport materials, goods, tools or equipment in connection with an occupation). The Board also included other personal vehicles (motorcycles, trailers and camper units, motorized snow vehicles, motor homes, off-road vehicles, and historic vehicles) in its consideration of this question (see paragraph 1.4).

9.2 The extension of the systems to include these other vehicles, and any particular rules relating to their inclusion, will obviously affect the estimated average prices of the options as set out in Chapter 8.

9.3 The Insurance Act gives the insurer a right of subrogation to the rights of recovery of the insured against any person (s. 242(1)). An insurer also has subrogation rights with respect to amounts paid out under uninsured motorist coverage (s. 231(5)). Where an insurer is subrogated to the insured, the insurer is deemed to stand in the place of the insured. The insurer can exercise all of the same claims, rights, duties and remedies which belong to the insured to effect recovery of the loss (paid by the insurer to the insured) from the third party causing the loss. Where the insurer denies coverage, the insurer defends in the name of its insured (s. 226). The insured is obliged to assist in subrogated efforts (s. 207).

B. FEASIBILITY

9.4 "Feasible" is defined in Webster's Ninth New Collegiate Dictionary (1988) to mean: 1. capable of being done or carried out; 2. capable of being used or dealt with successfully; 3. reasonable, likely. The Concise Oxford Dictionary (1982) defines "feasible" as meaning practicable, possible; (colloq.) manageable, convenient, serviceable, plausible.

C. THE THRESHOLD SYSTEMS

9.5 The Board notes that while it is "feasible" to include these other categories of automobile insurance in the threshold systems, there are reasons also to exclude these vehicles. If a threshold system is decided upon, the Government must consider from a public policy perspective the balance between these two extremes. The Ernst & Whinney report (Exhibit 21.3) did not make any comment on this issue except to note that some jurisdictions extend no fault to public and commercial vehicles and others do not: "Both approaches have worked in the United States" (at 6). Further, all five jurisdictions studied by Ernst & Whinney exclude motorcycles.

9.6 In the opinion of the Board, the balance in a threshold system should be in favour of including all categories.

1. Public and Commercial Vehicles

9.7 With respect to public vehicles, one issue, arising out of a concern about the affordability and availability of public transportation insurance, is which insurer should pay the no fault benefits, the public vehicle insurer or the passenger's insurer if the passenger has auto insurance. In New York, for instance, the "occupant rule" generally applies -- that is, no fault coverage follows the car a passenger-victim occupies and a pedestrian-victim looks to the car that hit the pedestrian. However a special rule was created for buses whereby victims look to their own insurers if they have one (Reierson, Transcript, at 806-07). Michigan has a similar rule with respect to passengers on public transportation (Creamer, Transcript, at 1287). The Board finds this to be an appropriate rule.

9.8 The Board does not suggest that this rule be applied to the category Public Vehicles - Taxis and Limousines. The incentive to develop risk management programs would be reduced if the no fault benefits were to be paid by other auto insurance policies. The premiums for these vehicles would not reflect their losses.

9.9 With respect to commercial vehicles, the major concern is that heavy commercial vehicles are "loss causers". Trucks, being bigger and heavier, cause a lot of damage to small vehicles and their occupants and the occupants of a truck are not likely to be seriously injured. In that the truck insurer, under a threshold no fault system, would not be responsible for some portion of the damage caused by its insured, there would be less incentive for trucking companies to continue with safety programs, premiums for truck insurance would decrease, and private passenger automobiles would be subsidizing the damage caused by the trucks.

9.10 The shift of the burden from large trucks to small vehicles creates an apparent inequity which has been addressed by jurisdictions in different ways. The most extreme measure is to exclude large commercial vehicles from the no fault system. Alternatively, there was testimony that some U.S. jurisdictions require the insurer for the large commercial vehicle to pay the no fault benefits in an accident with a private passenger automobile "on an absolute liability basis" (Perry, Transcript, at 5051). In Hawaii, there is provision for a loss transfer on an absolute liability basis for vehicles over 10,000 pounds (Submission of State Farm, at 4; Brown, Transcript, at 7361). In New York there is a right of subrogation where the accident involves a taxi or truck (Reiersen, Transcript, at 666-67).

9.11 There were submissions on the need for either the right of subrogation to enable a more precise calculation of premium (Transcript, Rogacki, Oakden, at 629-31), or loss transfers as done in Hawaii. Subrogation would ensure that the tortfeasor pays. While some parties supported subrogation (Progressive, Transcript, at 4065), some wanted to examine the issue to determine whether it was worthwhile (Dominion, Transcript, at 4248-49), and another took the position that the friction and the costs outweigh the benefits (State Farm, Transcript, at 5055, 7360). Subrogation would eliminate cross subsidization between public and commercial vehicles and private passenger automobiles. The Board finds that a right of subrogation in respect of accident benefits should be permitted where the accident involves a heavy commercial truck, taxi or limousine.

9.12 Another issue, also affecting both public and commercial vehicles, was the interaction between workers' compensation and a new insurance system. The evidence indicates that most threshold jurisdictions have placed workers' compensation benefits primary to the no fault benefits. This will favourably affect the premium rates for vehicles affected by workers' compensation (Exhibit 14.6, at 118). Further, as ARCH pointed out, both in its written and oral submissions, to the extent that a system excludes a tort action, subrogation would end and there would be "a consequential loss in funding to the Workers' Compensation Board (unless ... some type of bulk subrogation were put in place to replace the loss of the individually subrogated claims)" (Final Submission, at 13-14; Transcript, at 7288-89).

2. Motorcycles

9.13 The problems with including motorcycles in the threshold systems are that motorcycle riders are most likely to be seriously injured, costing more in terms of medical and rehabilitation benefits (they are "injury sufferers"), and that most motorcycle/car accidents are caused by the car. To insure motorcycles on a first party basis is riskier for insurers, as motorcycle riders are subject to a high risk of injury and their insurers would be responsible for potentially huge no fault payments. There were submissions that subrogation is essential for motorcycles if they are to be in the system (Progressive, Transcript, at 4065, 4179-80).

9.14 The evidence before the Board suggests that inclusion of motorcycles under no fault systems can lead to difficulties in terms of affordability and availability. Kentucky originally included motorcycles but discovered that insurance was too expensive to buy and so changed its system in 1976 to exclude motorcycles, although no fault benefits are available on an optional basis (Transcript, at 3223). Mr. Reierson indicted in his testimony that currently in New York motorcycle insurance is $150 a year and that it would increase to $500 or $600 if motorcycles were to be covered for no fault benefits

(Transcript, at 669). In Michigan, motorcycles are excluded from no fault provisions; however, if they are involved in an accident with a car, the motorcyclist can collect first party benefits from the insurer of the car regardless of fault. Michigan made a decision to spread the cost of motorcycle/car accidents among all cars (Creamer, Transcript, at 1287-89). Michigan also created the Michigan Catastrophic Claims Association, funded by assessments to all insurers, which reimburses companies for amounts paid out in excess of $250,000 for PIP benefits (Transcript, at 1401). An Ernst & Whinney witness commented that many of the larger losses in the Michigan Catastrophic Claims Association are caused by motorcycle injuries (Smith, Transcript, at 2779-81). In Hawaii, motorcycle owners must have no fault insurance, but motorcycle premiums are not based on motorcycle experience (Exhibit 14.6, at 119).

9.15 The options available to deal with motorcycles and no fault benefits include:

- exclude, and let them be insured under tort;
- exclude, but provide for minimum no fault benefits (the present level, MMIC, Transcript, at 5879-80) or optional no fault coverage (as in Kentucky);
- include, with a right of subrogation;
- include, and cross-subsidize (as in Hawaii);

- include, and if a motorcycle/car accident look to car policy, if a single vehicle accident, look to motorcycle policy (as in Michigan; Dominion, Transcript, at 4247);
- include, and set up an assigned claims plan for motorcycles, a pooling to support the payments of the no fault benefits (State Farm, Transcript, at 5053-54, 7361).

If excluded, there will be a need to deal with no fault benefits for pedestrians.

9.16 The Board has concluded that motorcycles should be included within the referred threshold systems subject, however, to a right of subrogation in respect of accident benefits. The Board sees no reason to exempt motorcyclists from the protection afforded by the no fault benefits. It is recognized that the effect of inclusion will be to increase motorcycle premiums; however, this effect should be mitigated by the right of subrogation.

3. Other Personal Vehicles

9.17 There was no evidence on whether to extend a threshold system to personal vehicles, other than private passenger automobiles and motorcycles. The Board finds that a threshold system could be extended to these other personal vehicles.

D. THE CHOICE SYSTEM

9.18 The Board finds that it is not "feasible" to extend the choice system to public and commercial vehicles, or to motorcycles, motorized snow vehicles, or off-road vehicles. The evidence before the Board indicated that no "choice" jurisdiction included commercial and public vehicles, or motorcycles. The terms of the Reference were vague as to how this system would work. No one could predict the consequences of a choice system. Further there was generally insufficient evidence and no experience before the Board to enable the Board to make a reasoned conclusion.

1. Public and Commercial Vehicles

9.19 One problem with both public and commercial vehicles operating under the choice system, in that many people drive these vehicles, is how the "choice" is made and how it commits people who did not make the choice. The problem is that owners would be making the choice for their employees who drive the vehicle, and, where a public vehicle, for the passengers who ride in the vehicle. Mr. Merin testified that there was confusion surrounding this issue in New Jersey (Transcript, at 3418). The Industry Coalition submitted that employee drivers of commercial vehicles should make the choice (Argument, at 14).

2. Motorcycles

9.20 The problems with motorcycles are exacerbated under the choice system, since a motorcycle insurer would be responsible not only for the motorcyclist who chooses choice no fault but also for the motorcyclist who chooses choice tort, both resulting in large payouts for the motorcycle insurer. Under either option motorcyclists would "see a fairly dramatic increase in their bodily injury premium" (Transcript, Oakden, at 282; and see Boulanger, Transcript, at 2205-06). Mr. Rogacki indicated that under choice, Progressive could only offer the choice tort option, because choice no fault "would be incredibly expensive" (Transcript, at 4083).

9.21 In Quebec, motorcycles are subsidized for about two thirds of their cost, notwithstanding a 40% premium increase last year; private passenger automobiles pay $91 and motorcycles $235 for bodily injury protection (Transcript, at 3078, 3109, 3124-25). The price of motorcycle insurance in Quebec has increased by approximately 150% in the period 1984 to 1988 (MMIC, Transcript, at 5877).

3. Other Personal Vehicles

9.22 The Board is of the opinion that problems similar to those surrounding motorcycles could be experienced by both motorized snow vehicles and off-road vehicles, namely that injuries to drivers of these vehicles could result in the payment of large no fault benefits by insurers, which would result in large premium increases for these categories. The Board is of the view, for this reason, that it is not feasible to extend the choice system to motorized snow vehicles and off-road vehicles.

9.23 The Board considers the categories trailers and camper units, motor homes and historic vehicles to be similar to the category private passenger automobiles. If the choice system is to be implemented for private passenger automobiles, the system could be extended to include these vehicles.

The Report of the Board is hereby respectfully submitted.

DATED AT NORTH YORK this 14th day of July, 1989

ONTARIO AUTOMOBILE INSURANCE BOARD

John P. Kruger
Chairman and Presiding Member

M. Elizabeth Atcheson

M. Elizabeth Atcheson
Vice Chair

M. Patricia Richardson
Vice Chair

APPENDIX A

Order in Council dated March 2, 1989
(the Reference)

Order in Council

Ontario

Executive Council

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that

WHEREAS the Lieutenant Governor in Council is empowered pursuant to section 28 of the Ontario Automobile Insurance Board Act, 1988, S.O.1988, Chapter 18, to require the Ontario Automobile Insurance Board to examine and report on any question related to automobile insurance that, in the opinion of the Lieutenant Governor in Council, requires a public hearing;

AND WHEREAS the Lieutenant Governor in Council has received many thoughtful and constructive suggestions to improve the private delivery of automobile insurance in Ontario, including those recommended in the Report of Inquiry into Motor Vehicle Accident Compensation in Ontario tabled in the Legislature on April 18, 1988;

AND WHEREAS, in response to these suggestions and recommendations, two alternate systems of privately delivered automobile insurance, threshold no fault and choice no fault, are under consideration by the Lieutenant Governor in Council;

AND WHEREAS the Lieutenant Governor in Council is of the opinion that there are various questions arising with respect to the alternate systems that require a public hearing in order to facilitate the Lieutenant Governor in Council in its considerations;

NOW THEREFORE on the recommendation of the Minister of Financial Institutions, the Lieutenant Governor by and with the advice and concurrence of the Executive Council, orders that the Ontario Automobile Insurance Board conduct public hearings to examine the threshold no fault system of privately delivered automobile insurance, with two specified thresholds, set out in Schedule 1 hereto, and the choice no fault system of privately delivered automobile insurance set out in Schedule 2 hereto, and report on the following:

> An estimation of the average prices that would be charged for automobile insurance policies within the referred systems, based on the mandatory classification system, the determinations of fact and rates established by the Ontario Automobile Insurance Board under its decision of February 13, 1989;
>
> The feasibility of extending the systems to public and commercial vehicles;

.../2

O.C. 612/89

The cost impact, if any, of the implementation of an alternative dispute resolution involving mediation and, if necessary, binding arbitration, for the settlement of no-fault compensation;

The administrative barriers that exist in relation to the systems that could result in significant additional costs either in implementation or in the continuing operation of the systems;

Whether there would be greater stability in the average prices charged for automobile insurance policies after implementation of the systems; and

An estimation of the level of recovery to injured persons that would be achieved under the systems.

AND THAT the Ontario Automobile Insurance Board commence public hearings on these questions and report back to the Lieutenant Governor in Council as soon as is practicable.

Recommended Murray J Elston
Minister of Financial Institutions

Concurred Murray J Elston
Chairman

Approved and Ordered March 2, 1989
Date

Lieutenant Governor

SCHEDULE 1

THRESHOLD NO FAULT

Threshold no fault is a system for compensating victims of automobile accidents in which a defined level of benefits is provided to individuals who are injured, irrespective of fault, and access to tort recovery is limited through a verbal threshold to serious cases.

In these cases, compensation is provided by way of no fault benefits from the victim's own insurer. These benefits include recovery for pecuniary (economic) losses, such as wage loss, medical and rehabilitation costs, and survivors' and funeral benefits. No fault benefit payments can be paid to the injured party relatively soon after the accident because no finding of fault is required, and the benefits are defined. Unless the degree of injuries meets the threshold, no recovery is permitted for non-pecuniary loss associated with the injury.

The threshold no fault compensation systems to be considered are based on the existing system of compensation in Ontario, with the following modifications:

a) The right of a person injured in an automobile accident to recover non-pecuniary damages sustained as the result of negligence of another is abolished, unless the level of bodily injury/impairment meets a defined threshold.

The two thresholds to be separately considered are:

i) death, serious impairment of a bodily function, or permanent serious disfigurement;

or

ii) death; dismemberment; significant disfigurement; loss of a fetus; a fracture; permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than 90 days during the 180 days immediately following the occurrence of the injury or impairment.

b) Those who are injured and who meet the threshold test can sue for non-pecuniary loss and all economic loss. Those who do not meet the threshold test can sue for economic loss. The economic loss that can be recovered against a wrongdoer in a lawsuit will be only those damages in excess of no fault benefits available under the policy. No fault benefits are:

Disability income benefits

1. Employed
80% of gross income, to maximum of $450 per week for life; 1 week waiting period; Benefits are primary to U.I.C. benefits only; non-primary to other benefits; recepient must be age 16 or older. Pension benefits received at age 65 are offset.

2. Deemed to be employed (i.e. worked 6 months in the last 12)
80% of gross income, to maximum of $450 per week; recipient must be between age 16 and 65 when injured to qualify; 60 day waiting period; Pension benefits received at age 65 are offset.

3. Students

$1,000 for each year lost of elementary school; $350* per week at age 18 if disabled and not attending school;

$2,000 for each year lost of secondary school; $340 per week at age 18 if disabled and not attending school;

$4,000 for each year lost of college or university; $340 per week when no longer entitled to loss of school year benefits.

Medical and Rehabilitation	$500,000 per claim with 10 year limit or 20 years minus victim's age, whichever is longer.
Long term care	Long Term Care is seperated from rehabilitation and capped at $500,000 per claim; Benefits are not to exceed the monthly cost of group residence which might reasonably accommodate victim's needs, having in mind the nature of injuries and other relevant factors; Family members of injured persons are included in long-term care compensation.
Death Benefits Head of Household or Spouse of Head of Household	$25,000
Dependant	$10,000
Funeral Benefits	$ 3,000
Replacement of Unpaid Home Worker Services	Home care benefit: $50 per week for incurred expenses; 1 week waiting period Child care benefit: $200 per week for recepient with child or dependant; additional $50 per week for recepient for each child or dependant to a maximum of $360; no waiting period.
Indexing	All benefits except the death benefit indexed once a year to annual consumer price index, subject to a maximum of twice the stipulated benefit.
Exclusions	No exclusions for driver conduct.

*The Ontario Automobile Insurance Board has been informed by the Ministry of Financial Institutions that the figure of $350 is a typographical error. The correct figure is $340.

SCHEDULE 2

CHOICE NO FAULT

The choice system would allow consumers to choose the form of compensation which they and their dependants would be entitled to receive in the event of bodily injury in an automobile accident. The choice would be made at the time of purchase of an insurance policy. Under this system, purchasers would be required to choose between two forms of insurance policy:

i) the no fault form, in which the insured would receive a defined level of benefits for pecuniary losses regardless of whether or not he or she was at fault in the accident, but the insured would not have the right to sue for non-pecuniary losses;

or

ii) the fault form in which the insured would retain the right to sue and recover for all losses, including non-pecuniary losses up to the limits of the insurance policy, if he or she can prove the other driver was at fault. These individuals would also have access to no fault benefits, as currently exist under schedule "C" of the Insurance Act.

Both policies would be delivered on a first party basis (i.e. injured persons would recover from their own insurer instead of the insurer of the vehicle that was at fault).

For the no fault form of policy, the no fault benefits would be:

Disability Income Benefits	1. **Employed** 80% of gross income, to maximum of $450 per week for life; 1 week waiting period; Benefits are primary to U.I.C. benefits only; non-primary to other benefits; Recepient must be age 16 or older. Pension benefits received at age 65 are offset. 2. **Deemed to be Employed (i.e. worked 6 months in the last 12)** 80% of gross income, to maximum of $450 per week; Recepient must be between age 16 and 65 when injured to qualify; 60 day waiting period; Pension benefits received at age 65 are offset.

	3. Students $1,000 for each year lost of elementary school; $340 per week at age 18 if disabled and not attending school; $2,000 for each year lost of secondary school; $340 per week at age 18 if disabled and not attending school; $4,000 for each year lost of college or university; $340 per week when no longer entitled to loss of school year benefits.
Medical and Rehabilitation	$500,000 per claim with 10 year limit or 20 years minus victim's age, whichever is longer.
Long Term Care	Long Term Care is separated from rehabilitation and capped at $500,000 per claim; Benefits are not to exceed the monthly cost of group residence which might reasonably accommodate victim's needs, having in mind the nature of injuries and other relevant factors; Family members of injured persons are included in long-term care compensation.
Death Benefits	
Head of Household or Spouse of Head of Household	$25,000
Dependant	$10,000
Funeral Benefits	$3,000
Replacement of Unpaid Home Worker Services	Home Care Benefit: $50 per week for incurred expenses; 1 week waiting period. Child Care Benefit: $200 per week with child or dependant; additional $50 per week for each child or dependant to a maximum of $350; no waiting period.

Indexing	All benefits except the death benefit indexed once a year to annual consumer price index, subject to a maximum of twice the stipulated benefit.
Exclusions	No exclusions for driver conduct.

The rules under which the choice no fault system would operate are as follows.

- A person who purchases the no fault form receives no fault compensation on injury or death based on a schedule of benefits set out in the policy without regard to fault but waives the right to recover for tort damages, including non-pecuniary damages.

- A person who purchases the fault form of policy retains the right to recover damages for injury or death as a result of a motor vehicle accident, based on an assessment by a court.

- All claims must be made directly against the insured's own insurer regardless of whether the fault or no fault form of policy is chosen.

- The choice made by the policyholder binds a spouse and financially dependent relatives living in the same home as the policyholder.

- Different vehicles of one household can be insured differently, so that one vehicle may be insured under a no fault form and another vehicle insured under a fault form, but children are bound by the decision of the parent that purchased the no fault form, so that children have automatic entitlement to defined benefits.

- All persons resident in Ontario, including those who are not presently insured under an automobile insurance policy, are deemed to have chosen tort recovery unless an election has been made to purchase a no fault form. Non-insured pedestrians can sue in tort as at present (i.e. the person who is at fault as opposed to their own insurance company); holders of the no fault policy would be required to carry a minimum of $200,000 liability insurance for this risk.

- Policyholders would be at liberty to move from a fault to a no fault policy and vice versa but the form of policy existing at the time of the accident always governs payment of claims.

- Where the motor vehicle accident happens outside of Ontario, the no fault benefits are still paid to the insured if the insured has chosen the no fault form of coverage.
- Persons resident outside of Ontario who are involved in accidents in Ontario may sue only in tort in Ontario, subject to any contrary provision of their insurance policy.
- No subrogation between insurers of vehicles would exist; no insurer could subrogate against any other insurer or person for payments made under either form of policy if the accident occurs in Ontario and the person responsible for the accident has either form of policy.

APPENDIX B

List of the Persons Served with Notice of Hearing; List of Newspapers in which Notice of Hearing was published

LIST OF PERSONS SERVED WITH NOTICE

A) INSURANCE INDUSTRY

Abstainer's Insurance Company
Advocate General Insurance Company of Canada
Aetna Casualty & Surety Company, The
Aetna Insurance Company
Algoma Mutual Fire Insurance Company
Allstate Insurance Company of Canada
Alpina Insurance Company Limited
American Home Assurance Company
American Road Insurance Company, The
American Mutual Liability
Anglo Canada General Insurance Company
Ayr Farmers' Mutual Fire Insurance Company, The
Bay of Quinte Agricultural Mutual Fire Insurance Company
Bertie & Clinton Mutual Fire Insurance Company
Blanshard Mutual Insurance Company
Brant Mutual Fire Insurance Company
CAA Insurance Company (Ontario)
Canada Accident & Fire Assurance Company, The
Canada Life Casualty Insurance Company
Canadian Commerce Insurance Company, The
Canadian General Insurance Company
Canadian Home Assurance Company
Canadian Indemnity Company, The
Canadian Provincial Insurance Company, The
Canadian Surety Company, The
Casualty Company of Canada, The
Cayuga Mutual Fire Insurance Company
Century Insurance Company of Canada, The
Chateau Insurance Company
Chrysler Insurance Company
Chubb Insurance Company of Canada
Cigna Insurance Company of Canada
Citadel General Assurance Company, The
Co-operators General Insurance Company
Coachman Insurance Company
Commerce & Industry Insurance Company of Canada
Commercial Union Assurance Company of Canada
Constitution Insurance Company of Canada
Continental Insurance Company of Canada, The
Continental Insurance Company, The
Contingency Insurance Company Limited, The
Cornhill Insurance Company of Canada
Cumis General Insurance Company
Dominion Insurance Corporation, The
Dominion of Canada General Insurance Company, The
Dufferin Mutual Insurance Company
Dumfries Mutual Insurance Company
Eaton Insurance Company
Ecclesiastical Insurance Office Public Limited Company
Economical Mutual Insurance Company
Elma Mutual Fire Insurance Company
Employers Insurance of Wausau, A Mutual Company
Erie Mutual Fire Insurance Company
Facility Association
Farm Mutual Reinsurance Plan Inc.
Farmers' Mutual Fire Insurance Company (Lindsay)
Federal Insurance Company
Federated Mutual Insurance Company
Federation Insurance Company of Canada
Firemen's Fund Insurance Company
First National Insurance Company of America
Formosa Mutual Insurance Company
Gan Incendie Accidents Compagnie Francaise D'Assurances
General Accident Assurance Company of Canada, The
General Insurance Company of America
Gibraltar General Insurance Company
Gore Mutual Insurance Company
Grenville Patron Mutual Fire Insurance Company
Guarantee Company of North America, The
Guardian Insurance Company of Canada
Halifax Insurance Company, The
Hamilton Township Farmers' Mutual Fire Insurance Company, The
Hanover Insurance Company, The
Hartford Insurance Company of Canada
Hartford Insurance Company, The
Hay Township Farmers' Mutual Fire Insurance Company
Herald Insurance Company
Home Insurance Company, The

Howard Mutual Fire Insurance Company
Howick Mutual Insurance Company
Insurance Company of North America
Jevco Insurance Company
Kingsway General Insurance Company
Lambton Mutual Insurance Company
Lanark Mutual Insurance Company
Laurentian Casualty Company of Canada
Laurentian General Insurance Company
Laurentian Shield Insurance Company, The
Liberty Mutual Fire Insurance Company
Liberty Mutual Insurance Company
Lobo Mutual Fire Insurance Company
London Township Mutual Insurance Company, The
Loyalist Insurance Company
Lumbermans Mutual Casualty Company
Lloyd's Non-Marine
Maplex General Insurance Company
Markel Insurance Company of Canada
McGillivray Mutual Fire Insurance Company
McKillop Mutual Insurance Company
Metro Public Education Insurance Exchange
Metropolitan Insurance Company
Missiquio and Rouville Insurance Company, The
Motors Insurance Corporation
New Hampshire Insurance Company
New Rotterdam Insurance Company
Niagara Fire Insurance Company
Non-Marine Underwriters, The, Members of Lloyd's, London, England
Norfolk Mutual Fire Insurance Company
North Blenheim Mutual Insurance Company
North Kent Mutual Fire Insurance Company
Northern Frontier General Insurance Company
Old Republic Insurance Company
Ontario School Boards' Insurance Exchange
Otter Dorchester Insurance Company Limited
Oxford Mutual Insurance Company
Pacific Employers Insurance Company
Pafco Insurance Company Limited
Pafco International
Peel & Maryborough Mutual Fire Insurance Company, The
Peel Mutual Insurance Company
Personal Insurance Company of Canada, The
Phoenix Assurance Company of Canada
Phoenix Assurance Company, Limited
Phoenix Insurance Company, The
Pilot Insurance Company
Portage la Prairie Mutual Insurance Company, The
Prescott Mutual Fire Insurance Company, The
Progressive Casualty Insurance Company
Prudential Assurance Company Limited, The (Of England)
Prudential of America General Insurance Company (Canada)
Quebec Assurance Company
Royal Insurance Company of Canada
Safeco Insurance Company of America
Scottish & York Insurance Company Limited
Security National Insurance Company
Sentry Insurance, A Mutual Company
Simcoe & Erie General Insurance Company
South Easthope Farmers' Mutual Insurance Company
Sovereign General Insurance Company, The
St. Paul Fire & Marine Insurance Company
Stanstead & Sherbrooke Insurance Company, The
State Farm Fire and Casualty Company
State Farm Mutual Automobile Insurance Company
Sun Alliance Insurance Company
Tokio Marine & Fire Insurance Company Limited, The
Toronto General Insurance Company
Townsend Farmers' Mutual Fire Insurance Company
Traders General Insurance Company
Trafalgar Insurance Company of Canada
Transit Insurance Company
Travelers Indemnity Company of Canada
Travelers Indemnity Company, The
Unifund Assurance Company
United Provinces Insurance Company, The
United States Fire Insurance Company
USF&G Insurance Company of Canada
Utica Mutual Insurance Company
Victoria Insurance Company of Canada
Wabisa Mutual Fire Insurance Company
Waterloo Insurance Company

Wawanesa Mutual Insurance Company, The
Wellington Insurance Company
West Elgin Mutual Fire Insurance
 Company
West Wawanosh Mutual Insurance
 Company, The
Western Assurance Company
Westminster Mutual Fire Insurance
 Company, The
Yasuda Fire & Marine Insurance Company,
 Limited
York Fire & Casualty Insurance Company
Zurich Insurance Company

B) OTHER PERSONS SERVED WITH NOTICE

Insurers' Advisory Organization
PMS
Realtime, A Division of Memotec Data Inc.
Karak Systems Corporation
Paxus Corporation
Polycom Systems Limited
Equifax Canada
A. L. Smoke
Chas A. Smith
Val L. Vanderquist
Advocacy Resource Centre for the Handicapped
Peter Hainer, P. Hainer Insurance Brokers Inc.
N. Paterson
David Neumann MPP for H. Wanders
Christina Giroulis
Board of Trade
L. Edur
Margaret Thompson
Roy W. Thompson
J. S. Andrews
James Draycott
Ainslie D. Aldridge
Claire Agranove
T. Yamamoto
John Griffin, John Griffin Associates Inc.
Edward J. Barbeau
J. Hamilton-Smith
Judith Revel
David G. Darby
Robert J. Hanley
Alfred Oakie, President
Hamilton Automobile Club
H. J. Baker
Robert J. Brooks
J. Lancastle
Susan & Ben Wichers-Schieur
Rita Tucker
Albert Baker
James Bean
"Bob", from Welland
John P. Charlton
Christine Conway
Agnes Gossen & Arthur Gossen
Pauline M. Gould-Corney
Peggy McKenna
Doris Penner
Yves Savoret
S. Suurmann
Sybil Thorn
Gerald J. S. Wilde
Evelyn Wong
S. Allan
Ed Buscombe
Karen Cardinal
K.H. Dunk
George Gibson
Carl R. Gregory
David A. Hilton
A. Ripkevicius
Anne Smith
G.A.N. Hitchlock
Eric J. Stone
Val Conway
Eva & Maurice Haist
Annetta E. Watson
Maureen Goodwin
Dawn Shepherd
Marion & Harold Weagle
"One of the many concerned citizens"
H. Belanger
R. Gauthier
Larry Howes
Harvey B. Kasman
Catherine Lovelock
J. & J. Proudfoot
Bert Shannon
Helen L. Thompson
H. Heanfour
M. Heanfour
Charlie Pullen
Doris E. Small
George Bednarough
Annette, Rene & Renee Corbeil
A. J. Cormack
C. Findlay
Marie-Louise Freundel
Gary C. Gauthier
Arlene Hummel
Mr. & Mrs. B. Loucks
Marcel M. Martel
Sally McKenzie
The Parkhouses
Doug Poulter
Betty Pringle
H. Puchala
Leslie Renaud
Ruth Sache
Monir Taha
June Waldie

Mr. & Mrs. R.M. Brown
Helen, Lynn & B. Cratt
Rachel Lariviere
Jack Lee
Albert & Marietta Parisien
Timothy Tog
Alan Nunn
Arthur Pilkington
Michael Sava
Philip Golden
R. Emmons
Michael Grunte
F. Turple
Mary Hall
B. L. DeGeer
N. & J. Heald
R. L. Small
G. Dobbs
Paul & Frank Hampt
P. E. Odell
W. Rumble
Robert Truchon
Rod Vincent
D. Fiorese
O. Fiorese
Betty Shute
William Toleff
Stephanie van Niekerk
Mary Witte
Mr. & Mrs. F. Pratt
A. L. Browne
Jessie V. Gatfield
Glady Coulter
K. Gehrke
Rose Marie Pongratz
Bev Richardson
Denis Richardson
Loraine Small
Marianne Small
Robert Small
J. Robert Skinning
I. Brosnan
Mark Edwards
H. Answell
Dorothy Grundon
Len & Cecile Janesil
Stella Logan
Mr. & Mrs. W. E. Matthews
Paul De. Ruyte
Lorne Yade
R. P. Buckingham
J. David Dorbrindt
Jack & Anne Gould
Joseph Moreau
Laird Nixon
A. V. Scott
Margaret M. Stokes
Hannes Broschek
Laura Feeney
A. LaFortun
James LaFortune
Tom LaFortune
J. Cressman
Joe & R. Taliana
Joan Bruder
A. Planeshour
Nancy & Bob Bryans
L. Anderson
LLoyd Robert Van Slyke
John C. Chursina
Louis St. Denis
Larry Hartin
William Sarene
Edward Rattai
Irwin Andrew
Donna Chevrier
R. Palin
Donald B. Way
D. B. Homavazir
J. A. Barnes
Bev & Ray Jones
Leroy Wright
A. Chamot
Hugh Brennan
B. Milloy
Ellenor Jones
Armand & Jean James
Sandra Kendrick
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Working with Seniors
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Ruth Borthwick
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Canadian Motorcycle Association (Ontario Region)
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Insurance Bureau of Canada et al.
Safeco Insurance Companies
Laurentian Casualty Company of Canada
Baird & MacGregor Insurance Brokers Inc.
Independent Cab Owners Co-operative Incorporated
Commercial Union Canada
Association of Canadian Insurers
Ontario Motorcycle Dealers Association
William M. Mercer Ltd.
Robinson & Jones Insurance Brokers & McClean Association
Jevco Insurance Management Inc.
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Quinn Smith (Bikers Rights of Ontario, Inc.)
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Gerry German (Ontario Road Riders Association)
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John P. Carlton
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LIST OF NEWSPAPERS IN WHICH NOTICE OF HEARING DATED MARCH 9, 1989 WAS PUBLISHED

The Sudbury Star

Le Droit

The Ottawa Citizen

The Globe and Mail

The Toronto Star

The Toronto Sun

The London Free Press

The Thunder Bay Times-New/Chronicle-Journal

Toronto L'Express

Sudbury Le Voyageur

Windsor Le Rampart

LIST OF NEWSPAPERS IN WHICH NOTICE OF HEARING DATED MARCH 9, 1989 WAS PUBLISHED

Cornwall Le Journal-Opscom
Hawkesbury Le Carillon-Opscom
Hearst Le Nord-Opscom
Mississauga Horizon Sud
L'Express d'Orleans-Opscom
Le Courrier d'Oshawa
Le Nord de Kapuskassing
L'Edition Prescott Russell-Opscom
Sturgeon Falls Tribune
Sudbury Le Voyageur-Opscom
Toronto L'Express
Vanier Le Journal-Opscom
Windsor Le Rempart-Opscom
Alexandria Glengarry News
Alliston Herald
Aylmer Express
Almonte Gazette
Amherstburg Echo
Arnprior Chronicle Guide
Arthur Enterprise News
Atikokan Progress
Ayr News
Bancroft Times
Barry's Bay this Week (Madawasks Valley)
Beeton Innisfil Scope
Beeton Record Sentinel/Tottenham Times
Belleville Quinte Weekly News
Blenheim News-Tribune
Blyth Citizen
Bowmanville Canadian Statesman
Bobcaygeon Independent
Bothwell Times
Bracebridge Examiner
Bracebridge Herald-Gazette
Bracebridge Muskoka Advance
Brighton Independent
Burks Falls/Powassan Almaguin News
Beaver Express/Cannington Gleaner
Caledon Citizen
Carleton Place Canadian
Cayuga Regional News This Week
Cobden Sun
Campbellford Courier
Campbellford Herald
Rainbow Report
Chesley Enterprise
Chapleau Sentinel
Chesterville Record
Colborne Chronicle
Caledonia Grand River Sachem
Cochrane Northland Post
Collingwood Enterprise-Bulletin
Creemore Star
Deep River North Renfrew Times
Delhi News-Record
Dundalk Herald
Dunnville Chronicle
Dorchester Sign Post
Drayton Community News
Dresden North Kent Leader
Dryden Observer
Durham Chronicle
Dutton Advance
Dowling Onaping Falls News
Eganville Leader
Elliot Lake Standard
Elliot Lake Tabloyd
Elmira Independent
Elmvale Lance/Wasaga Times
Erin Advocate
Espanola Mid-North Monitor
Exeter Times-Advocate
Fenelon Falls Gazette
Fenelon Falls North Kawartha Times
Flesherton Advance
Forest Standard
Frankford Advertiser
Fergus-Elora News Express
Fergus-Wellington Advertiser
Gananoque Reporter
Georgetown Halton Hills Herald
Geraldton Times-Star
Glencoe Alvinston Transcript & Free Press
Goderich Signal Star Group
Gore Bay Manitoulin Recorder
Gravenhurst Banner
Gravenhurst News
Grand Valley Star & Vidette
Hagersville Haldimand Press
Havelock Citizen
Harriston Review
Hastings Star
Hawkesbury Express
Haliburton County Echo & Minden Recorder

APPENDIX C

Notice of Hearing dated March 9, 1989;
Procedural Order - 1 dated April 7, 1989

Ontario
Automobile
Insurance
Board

Commission de
l'assurance-
automobile
de l'Ontario

Ontario

IN THE MATTER OF the Ontario Automobile Insurance Board Act, 1988, S.O. 1988, c.18.

AND IN THE MATTER OF a reference made by the Lieutenant Governor in Council pursuant to section 28 of the said Act.

NOTICE OF HEARING

THE ONTARIO AUTOMOBILE INSURANCE BOARD (the "Board"), at the request of the Lieutenant Governor in Council, will hold a Hearing pursuant to section 28 of the Ontario Automobile Insurance Board Act, 1988, S.O. 1988, c.18.

Purpose of the Hearing

The Lieutenant Governor in Council has ordered the Board to conduct public hearings to examine the threshold no fault system of privately delivered automobile insurance (with two specified thresholds), and the choice no fault system of privately delivered automobile insurance. The Order in Council dated March 2, 1989 (the "Reference"), containing the details of the systems under consideration, is available upon request.

The Lieutenant Governor in Council has specifically ordered the Board to report on the following:

1. An estimation of the average prices that would be charged for automobile insurance policies within the referred systems, based on the mandatory classification system, the determinations of fact and rates established by the Ontario Automobile Insurance Board under its decision of February 13, 1989;
2. The feasibility of extending the systems to public and commercial vehicles;
3. The cost impact, if any, of the implementation of an alternative dispute resolution involving mediation and, if necessary, binding arbitration, for the settlement of no-fault compensation;
4. The administrative barriers that exist in relation to the systems that could result in significant additional costs either in implementation or in the continuing operation of the systems;
5. Whether there would be greater stability in the average prices charged for automobile insurance policies after implementation of the systems; and
6. An estimation of the level of recovery to injured persons that would be achieved under the systems.

The Board is to commence public hearings and report back to the Lieutenant Governor in Council as soon as is practicable.

The Hearing

THE HEARING will be held under File No. R-89-1 and will commence on Wednesday, April 12, 1989 at 9 o'clock a.m. in the Board's Hearing Room, 2nd Floor, 5 Park Home Avenue, North York.

A PRE-HEARING CONFERENCE will be held on Tuesday, March 21, 1989 at 2:30 p.m. in the Board's Hearing Room to deal with preliminary matters, including, but not limited to the following:

- written evidence to be pre-filed
- the interrogatory process
- the hearing process
- issues

The Board has engaged a consultant to assist the Board. The consultant will price the two systems of privately delivered automobile insurance as set out in the Reference. This evidence will be pre-filed on or before Monday, April 3, 1989.

A SECOND PRE-HEARING CONFERENCE will be held on Friday, April 7, 1989 at 9:00 a.m. in the Board's Hearing Room to settle the issues and to deal with any other procedural matters.

IF YOU WISH TO PARTICIPATE AS A PARTY IN THE HEARING, you (or your lawyer or agent) must file with the Board a written notice of your intention to participate as a party on or before Tuesday, March 21, 1989. A person who files such a notice intends to participate fully in the hearing.

INSTEAD OF PARTICIPATING AS A PARTY IN THE HEARING, you may comment on any of the issues as a LIMITED INTERVENOR by filing a letter of comment with the Board. A letter of comment should clearly state your views, set out the grounds and the factual basis for your position, and indicate whether you intend to make an oral presentation to the Board. Letters of comment must be filed at the Board's office on or before Thursday, April 20, 1989.

ALL DOCUMENTS FILED IN THIS PROCEEDING are available for viewing at the Board's office during office hours Monday to Friday, 8:30 a.m. to 4:45 p.m.

PROCEDURAL ORDERS as to how the matter will proceed may be issued from time to time. Copies of any procedural orders will be sent to all parties.

IF YOU DO NOT BECOME A PARTY TO THE HEARING OR INDICATE THAT YOU WISH TO MAKE AN ORAL PRESENTATION TO THE BOARD, THE BOARD MAY PROCEED IN YOUR ABSENCE AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE OF THESE PROCEEDINGS.

DATED AT NORTH YORK this 9th day of March, 1989.

Ontario

ONTARIO AUTOMOBILE
INSURANCE BOARD
4th Floor, 5 Park Home Avenue
North York, Ontario
M2N 6L4
Phone No. (416) 222-2886
Fax No. (416) 730-7761

Toll Free: 1-(800)-668-0128
(English)
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Attn: Sophia Coroyannakis
Board Secretary

Ces avis est disponible en version francaise.

Ontario
Ontario Automobile Insurance Board
Commission de l'assurance-automobile de l'Ontario

File No. R-89-1

IN THE MATTER OF the Ontario Automobile Insurance Board Act, 1988, S.O. 1988, c. 18;

AND IN THE MATTER OF a reference made by the Lieutenant Governor in Council pursuant to section 28 of the said Act.

BEFORE:	John P. Kruger, Chairman and Presiding Member M. Elizabeth Atcheson, Vice Chair M. Patricia Richardson, Vice Chair	April 7, 1989

Procedural Order - 1

UPON the Ontario Automobile Insurance Board (the "Board") having received an Order-in-Council from the Lieutenant Governor in Council dated March 2, 1989, pursuant to section 28 of the Ontario Automobile Insurance Board Act, 1988, ordering the Board to conduct public hearings to examine two systems of privately delivered automobile insurance, the threshold no-fault system (with two specified thresholds) and the choice no-fault system (the "Reference");

AND WHEREAS the Board issued a Notice of Hearing dated March 9, 1989, setting out the purpose of the Hearing and the times and place for the pre-hearing-conferences, and appointing Wednesday, April 12, 1989 as the commencement of the Hearing;

AND WHEREAS the Board held the pre-hearing-conferences on March 21, 1989 and April 7, 1989, in which procedural matters and issues for the Hearing were discussed;

AND WHEREAS the Board is mindful of the requirement set out in the Reference requiring the Board to report back to the Lieutenant Governor in Council as soon as is practicable;

AND WHEREAS the Board is of the opinion that a short delay in the commencement of the Hearing would benefit all participants;

AND WHEREAS the Board is of the opinion that it is necessary at this time to make procedural provisions for the Hearing and that it would be expedient to develop a list of issues to provide direction to the parties;

IT IS ORDERED THAT:

1. The Hearing will commence at 9:00 a.m. on Monday, April 17, 1989. The Board will sit daily thereafter from 9:30 a.m. to 5:00 p.m. (This timetable is subject to adjustment.)

2. (a) Parties who wish to ask interrogatories on the "Costing of Alternative Compensation Systems for the Victims of Automobile Accidents", prepared by Tillinghast, a Towers Perrin Company, dated April 3, 1989 (the "Tillinghast Report") shall do so by written interrogatories filed with the Board on or before Friday, April 7, 1989.

   (b) Responses to said interrogatories may either be filed with the Board and provided to the parties who requested the written evidence before the commencement of the Hearing, or may be given orally in examination-in-chief by the appropriate witness during the Hearing.

3. (a) Parties who wish to submit written evidence shall do so by filing it with the Board and providing a copy to the parties who requested the written evidence, on or before Monday, April 17, 1989.

   (b) Parties who wish to ask interrogatories of other parties' evidence may do so by written interrogatories filed with the Board and provided to the party on or before Friday, April 21, 1989.

   (c) Responses to said interrogatories are to be made by the earlier of Friday, April 28, 1989 or the date of testimony.

4. (a) Each party shall provide the Board with fifteen (15) copies of every filing, except where the material proposed

to be filed is of the general research variety, and then only two copies shall be filed.

(b) Each party is responsible for distributing its own evidence, interrogatories and filings to other parties in the Hearing.

5. (a) The list of issues, attached as Appendix "A" to this Order, are the issues which parties should address in the Hearing.

(b) If a party wishes to add a further issue, the party should make a motion to the Board further to Rule 8 of the Draft Rules of Practice and Procedure for Hearings commencing August 1988.

ISSUED AT NORTH YORK this 11th day of April, 1989.

S. Coroyannakis

S. Coroyannakis
Board Secretary

ONTARIO AUTOMOBILE INSURANCE BOARD
5 Park Home Avenue, 4th Floor
North York, Ontario
M2N 6L4

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Fax No. (416) 730-7761

Toll Free: 1-(800)-668-0128 (English)
1-(800)-668-0249 (French)

Appendix 'A'
To Procedural Order - 1
Dated April 7, 1989
Under File No. R-89-1

S. Coroyannakis

S. Coroyannakis
Board Secretary

ISSUES LIST

FILE No. R-89-1

ESTIMATION OF AVERAGE PRICES

Threshold no-fault/Choice:

1. What is the overall cost impact of implementing the systems under consideration? For example, what is the impact of legal fees and other associated costs of litigation, and adjusting, and brokerage costs, etc., upon the average prices that would be charged for automobile insurance policies under the referred systems?
2. What assumptions have been made in estimating the costs with respect to administrative costs, utilization, legal costs, etc.? Are these assumptions reasonable?
3. Are these assumptions reasonable in the context of the experience of other jurisdictions that have implemented these types of systems?
4. What degree of confidence is associated with the costings as determined under these systems?
5. Will the average price of insurance decrease in Ontario if one of these systems is adopted? If so, by how much?
6. What factors will determine whether an individual's premium is higher or lower than the average?
7. How effective will the two thresholds be in eliminating claims?
8. How might the courts interpret the two thresholds?
9. How do the costs of these systems compare with the experience of other jurisdictions?
10. What are the costs of the individual components of the systems? For example, what are the costs of preserving the right to recover nonpecuniary losses for claims which meet the threshold?

STABILITY OF PRICES

Threshold no-fault:

11. Will the savings, if any, from reduced tort litigation be sufficient to finance the new no-fault benefits without a premium increase?

12. Will the savings, if any, be sufficient to fund increased benefits, as proposed, and also reduce premiums? If so, by how much?

13. Will costs increase because of greater utilization?

14. What relevant information is available from experience in other jurisdictions?

15. How sensitive are prices to other cost factors like distribution costs, administration costs, and vehicle costs? How will these costs be controlled?

Choice:

16. Are there significant administrative costs, either direct or indirect, from the duplicate systems? If so, what are they?

17. What impact will the choice system have on the distribution scheme?

18. How will the price of a tort policy be affected by the number of people who select no-fault policies?

19. Will people tend to chose a cheaper policy? What other factors will determine their choice? What is the profile of the average insured in each group? For example, under the choice system, will economically disadvantaged persons be more inclined to choose coverages which will provide less coverage in the event of serious injury? What has been the experience of other jurisdictions?

20. Will most high-risk drivers tend to choose no-fault coverage, resulting in future price increases for this type of coverage, i.e., adverse selection problem/cross-subsidization?

21. How will the elimination of subrogation rights affect the pricing of insurance?

LEVEL OF RECOVERY TO INJURED PERSONS

Threshold no-fault/Choice:

22. How will the implementation of either of the systems, either no-fault or choice, affect the level of recovery of injured persons?

23. How have disability and rehabilitation benefits been delivered in the past? Will that change under the proposed threshold no-fault and choice systems? If so, how?

24. Will there be a reallocation of the burden of providing for recovery of injured persons from the auto insurers to social services? If so, what will be the indirect costs?

25. What types of injuries will, in practice, go uncompensated?

26. To what extent would the level of compensation vary across different classes of injured persons?

27. Will claims be paid out more quickly to injured persons? If so, how will this impact the investment income of insurance companies?

28. What is the experience of other jurisdictions with respect to total claims payouts after implementing these types of systems?

29. Will there be a reduction or reallocation of insurance premium dollars to other forms of insurance? Is replacement coverage available? Will premium rates rise on these other forms of insurance?

30. What impact would the various proposals have on the availability of other disability, medical and rehabilitation benefits?

31. What effect, if any, would implementation of the systems under consideration have upon the limits of insurance generally available to claimants, including pedestrians, passengers, or out of province claimants?

ADMINISTRATIVE ISSUES

Threshold no-fault/Choice:

32. What administrative problems have been experienced by other jurisdictions that have adopted these types of systems?

33. Are there any other administrative barriers unique to Ontario that would affect implementation?

34. Who will determine whether the injured party meets the threshold?

35. Are there anticipated constitutional or other legal issues which may be raised which may increase the legal or administrative costs under these systems?

36. Would rights to claim under the provisions of the Family Law Act be affected?

37. How would the conversion to the proposed systems be implemented, and over what period?

38. What changes in the delivery system would be required, and at what cost?

39. What practical complications will be encountered? For example, what happens when a driver with no-fault insurance is sued by a driver from a jurisdiction with tort coverage?

40. How will the consumer be educated?

COST IMPACT OF ALTERNATIVE DISPUTE RESOLUTION ("ADR")

Threshold no-fault/Choice:

41. What types of ADR mechanisms could be used to resolve disputes? What are the advantages and disadvantages of each?

42. What terms would define access to the ADR mechanism?

43. How would actions be initiated, by whom, over what time period, and at what cost?

44. What right of appeal is contemplated?

45. Who will bear the costs of this process? How would these costs impact the average price to be charged for insurance?

46. Will there be any costs savings if some form of ADR is implemented?

47. Have any other jurisdictions that have adopted no-fault systems used ADR to resolve disputes? What has their experience been? Have any cost savings been realized with ADR?

FEASIBILITY OF EXTENDING SYSTEMS TO PUBLIC VEHICLES, COMMERCIAL VEHICLES, AND PERSONAL VEHICLES, OTHER THAN PRIVATE PASSENGER AUTOMOBILES

Threshold no-fault:

48. Is there any reason why all vehicles could not or should not be included in this system?

49. Have any other jurisdictions included public and commercial vehicles and personal vehicles, other than private passenger automobiles, under a no-fault system of insurance? What has their experience been?

50. Do accident settlements for public and commercial vehicles and personal vehicles, other than private passenger automobiles, affect the cost of auto insurance for private passenger automobiles?

51. How would this interact with the WCB system?

Choice: (same as above, and)

52. Would public vehicles really have a choice of insurance coverage?

REGULATORY AND OTHER MATTERS

Threshold no-fault/Choice:

53. What will be the role of the OAIB in rate setting under these systems?

54. What effect would either of these systems have on the pricing or availability of reinsurance?

55. Would the implementation of either of these systems affect the Board Class Plan?

APPENDIX D

List of Parties who appeared, the Limited Intervenors, and the Witnesses

Party	**Representative(s)**	**Witness(es)**
Advocacy Resource Centre for the Handicapped (ARCH)	H. Beatty	Dr. D. Corey Director, Behavioural Health Clinic, Toronto, Ontario
Canadian Bar Association (Ontario) (CBAO)	J. Keaney B. Atherton L. Edroos J. Withrow P. Samworth R. Sugar	
Consumers' Association of Canada (Ontario) (CAC)	E. Belobaba C. Baggaley CAC Staff R. Healy R. Elliott	R. Hunter Actuarial Consultant, National Insurance Consumers' Organization, Alexandria, Virginia
The Committee for Fair Action In Insurance Reform (FAIR)	L. Mandel J. Morse	E. Cherniak Senior Partner, Lerner & Associates, Barristers & Solicitors, London J. Seigel Chartered Accountant, Partner, Laventhol & Horwath Management Consultants M. Berenblut Partner, Berenblut and Rosen Ltd., Chartered Business Valuators and Litigation Accountants N. Fowler Accident Victim, Pickering, Ontario J. Carr Professor of Economics, University of Toronto G. Priest Professor of Law and Economics, Yale Law School G. Baker Attorney, Baker, Garber, Duffy & Pedersen, P.C., Hoboken, New Jersey S. Miller Attorney, Lopatin, Miller, Freedman, Bluestone, Erlich, Rosen & Bartnick Detroit, Michigan

Party	**Representative(s)**	**Witness(es)**
Fred Hill		F. Hill Scarborough, Ontario
Insurance Brokers Association of Ontario (IBAO)	D. Dorsch	J. Strype Partner, Thomson, Rogers Barristers & Solicitors D. Yeates Principal, Yeates & Associates Insurance Brokers Limited R. Griffith Partner, Coburn, Griffiths & Brandham Insurance Brokers Ltd. T. Taylor Assistant General Manager, IBAO
Insurance Bureau of Canada The Insurers' Advisory Organization Inc. The Association of Canadian Insurers The Facility Association The Ontario Mutual Insurance Association Certain independent non-aligned insurers (Industry Coalition)	N. Finkelstein J. Galway A. O'Donnell	R. Miller Actuarial Consultant, The Wyatt Company S. Groot Vice President & Chief Actuary, Allstate Insurance Company (U.S.) F. Boulanger Assistant Vice President of Actuarial Services & Corporate Management Information, Allstate Insurance Company of Canada T. Kelaher President, Allstate (Canada) R. Rogers Territorial Claims Manager, Allstate (Canada) G. Zwaal Vice President of Administration, Allstate (Canada) R. Elms President & CEO, Royal Insurance Company of Canada A. Williams Personalized Automobile Manager, Royal E. Chick Vice President of Claims, Royal

Party	Representative(s)	Witness(es)
State Farm Insurance Companies	H. Brown	S. Lehmann Senior Actuary, State Farm Mutual, Bloomington, Illinois J. Perry Associate General Counsel, State Farm Mutual C. Fraser Deputy Regional Vice President, Canada, State Farm Insurance Companies

Board Counsel	Witness(es)
D. Rogers J. Strung C. Cottle	D. Oakden Actuarial Consultant, Tillinghast M. Trudeau Actuarial Consultant, Tillinghast J. Reiersen Chief Insurance Examiner, New York State Insurance Department J. Schnitter Attorney, Saperston & Day, P.C., Buffalo, New York N. Sherman Executive Director, Arbitrators' Institute of Canada Inc. (AIC) G. Donnelly Vice President of Development, AIC H. Consky Member, AIC C. Ashby Barrister & Solicitor, The Private Court W. Graham Professor, University of Toronto, Faculty of Law T. Creamer Director of Research and Analysis, Insurance Bureau of Michigan G. Gromek Attorney, Plunkett & Cooney, P.C., Detroit, Michigan N. Bergeron Claims Manager, Régie del'assurance automobile du Quebec M. Breton Actuary, Régie

Party	Representative(s)	Witness(es)
Industry Coalition cont'd.		W. Leong Director of Actuarial Department, Royal T. Boyle Claims, Royal C. Bryan Partner, Ernst & Whinney, New York L. Smith Partner, Ernst & Whinney, Chicago, Illinois M. McIntyre President, Ontario Mutual Insurance Association (OMIA) G. Johnson Vice President, OMIA R. Perry Chairman, OMIA D. Bailey Underwriting Manager, Farm Mutual Reinsurance Plan, Member, OMIA D. Waugh President & Managing Director, Dominion of Canada Insurance Company J. Christie Vice President & Chief Actuary, Dominion L. McCubbin Vice President Claims, Dominion
KRG Inc.	R. Goldner Chairman & CEO	R. Goldner
Kingsway General Insurance Company	W. Star President R. Wingfield Vice President	W. Star R. Wingfield P. Singh Claims Manager M. Goetz Claims Adjuster
Progressive Casualty Insurance Company	A. Rogacki Chief Agent V. Politzi Claims Manager	A. Rogacki V. Politzi W. Conner Project Manager, U.S J. Dailey Claims Manager, U.S.

Board Counsel	Witness(es)
cont'd.	P. Watts General Counsel, Kentucky Department of Insurance
	M. Powers Deputy Insurance Commissioner, Office of Rate and Policy Regulation, Pennsylvania Department of Insurance
	K. Merin Commissioner of Insurance, State of New Jersey
	M. Rossi, III President, Independent Insurance Agents of New Jersey (IIANJ)
	B. Dolin President-Elect, IIANJ
	Judge G. Killeen Senior Judge, Middlesex District Court
	J. Evans Economic Consultant, Econanalysis & Associates (Econanalysis)
	M. Zukowski Economic Consultant, Econanalysis
	M. Krashinsky Economic Consultant, Econanalysis
	Justice C. Osborne Justice, Supreme Court of Ontario
	B. Baptiste Director and President, Rehabilitation Management Inc.
	Dr. J. Staub Director of Psychiatry, Sunnybrook Hospital
	Dr. W. Franks Director of Neuro-rehabilitation Unit, West Park Hospital
	R. Rempel Executive Director, Ontario Head Injury Association
	K. Rowe Executive Director, Canadian Paraplegic Association

LIMITED INTERVENORS - WRITTEN SUBMISSIONS

Exhibit	Intervenor
3.1	Scott D. Mitchell, Harold J. Mitchell Insurance Limited, letter dated January 27,1989
3.2	Steve Placek, Placek & Associates, letter dated March 15, 1989
3.3	Mike De Hetre, letter dated March 16, 1989
3.4	Rose Marie Pongratz, letter dated March 20, 1989
3.5	Merv dePendleton, Citizens Against Rising Rates, letter dated March 19, 1989
3.5(a)	Letter received May 8, 1989
3.6	Steve Beacock, letter dated March 22, 1989
3.7	Mary E. Chapman, Niagara Falls Taxi Ltd., letter dated March 21, 1989
3.8	F.W. Doran, letter received March 30, 1989
3.9	Lawrence Schauber, letter dated March 30, 1989
3.10	R. Kearney, The Ontario Chamber of Commerce, letter dated March 31, 1989
3.11	Ruth Stuart, letter dated April 4, 1989
3.12	Mary Witte, letter date April 10, 1989
3.13	Murray A. Segal, Eckler Partners Ltd. Consulting Actuaries, letter dated April 10, 1989
3.14	Robert Ramsay, Motorcycle & Moped Industry Council, letter dated April 6, 1989
3.15	Harry Noel Ettinger, letter dated April 13, 1989
3.16	Alan W. Bangay, letter dated April 6, 1989
3.17	Kirby Rowe, Canadian Paraplegic Association, letter dated April 19, 1989
3.18	Catharine de Leeuw, The Ontario Coalition of Non-Profit Organizations Working With Seniors, letter dated April 19, 1989
3.19	C.R. Eddie, C.R. Eddie Engineering Inc., letter dated April 20, 1989
3.20	Robert Ramsay, Motorcycle and Moped Industry Council, received April 20, 1989
3.21	Allan T. Walton, Pain Management Behaviourial Rehabilitation Clinic, letter dated April 19, 1989
3.22	Angus Ross, letter dated April 20, 1989
3.23	Vira Persichilli, Motorcycle Dealers Association, letter dated April 19, 1989
3.24	Ontario Trucking Association, submission dated April 1989
3.25	Barbara O'Brien, letter received April 21, 1989
3.26	Steve Crouse, letter dated January 26, 1989
3.27	Eve Corvese, letter dated May 12, 1989
3.28	Dermot P. Nolan, Hamilton Law Association, letter dated May 10, 1989
3.29	Alfred U. Oakie, President, Hamilton Auto Club, submission received May 24, 1989
3.30	Ronald H. Switzer, Liberty Mutual Insurance Company, dated May 29, 1989
3.31	Allan Johnson, Canadian Vintage Motorcycle Group, submission received May 29, 1989

LIMITED INTERVENORS - ORAL SUBMISSIONS

NAME	VOLUME #	DATE
Steve Crouse, BAAT FIVE	XVII	May 12/89
Robert Ramsay, MMIC	XXIV	May 23/89
Angus Ross	XXIV	May 23/89
Hamilton Auto Club, A. Oakie, President Catherine Newell	XXV	May 24/89
John Carson	XXVI	May 25/89

APPENDIX E

Index to the Transcripts

VOLUMES I/II/III APRIL 17/18/19/89

Michel Trudeau David Oakden 17 - 160 164 - 385 388 - 638	TILLINGHAST, A TOWERS PERRIN COMPANY

VOLUME IV APRIL 20/89

John Reiersen 640 - 820	NEW YORK STATE INSURANCE DEPARTMENT
Joseph Schnitter 821 - 908	SAPERSTON & DAY, P.C. BUFFALO, NEW YORK
Trudeau Oakden 909 - 943	TILLINGHAST

VOLUME V APRIL 24/89

Norman Sherman Gordon Donnelly Harvey Consky 954 - 1125	ARBITRATORS' INSTITUTE OF CANADA INC.
Christopher Ashby 1126 - 1167	THE PRIVATE COURT
William Graham 1168 - 1257	UNIVERSITY OF TORONTO, FACULTY OF LAW

VOLUME VI APRIL 25/89

Terri Creamer 1259 - 1407	INSURANCE BUREAU OF MICHIGAN
Gregory Gromek 1409 - 1537	PLUNKETT & COONEY, P.C. DETROIT, MICHIGAN

VOLUMES VII & VIII APRIL 26/27/89

Ronald Miller 1545 - 1787 1791 - 2066	THE WYATT COMPANY

VOLUME IX MAY 1/89

Miller 2068 - 2080	WYATT
Steven Groot Francois Boulanger Terry Kelaher Robert Roger Gerrit Zwaal 2083 - 2356	ALLSTATE INSURANCE COMPANY OF CANADA

VOLUME X MAY 2/89

Boulanger Kelaher Roger Zwaal 2360 - 2600	ALLSTATE
Art Williams Roy Elms Edward Chick Winsome Leong 2604 - 2721	ROYAL INSURANCE COMPANY OF CANADA

VOLUME XI MAY 3/89

Chuck Bryan Lee Smith 2722 - 3033	ERNST & WHINNEY (U.S.)

VOLUME XII MAY 4/89

Normand Bergeron Martin Breton 3036 - 3197	REGIE DE L'ASSURANCE AUTOMOBILE DU QUEBEC

VOLUME XIII MAY 5/89

Patrick Watts 3202 - 3308	DEPARTMENT OF INSURANCE, STATE OF KENTUCKY

Michael Powers **3309 - 3375**		**PENNSYLVANIA DEPARTMENT OF INSURANCE**
VOLUME XIV	**MAY 8/89**	
Kenneth Merin **3378 - 3565**		**STATE OF NEW JERSEY**
Bruce Dolin Michael Rossi, III **3567 - 3674**		**INDEPENDENT INSURANCE AGENTS OF NEW JERSEY**
VOLUME XV	**MAY 9/89**	
Earl Cherniak **3681 - 3833**		**LERNER & ASSOCIATES** **LONDON, ONTARIO**
Mel McIntyre Glen Johnson Ron Perry David Bailey **3834 - 3917**		**ONTARIO MUTUAL INSURANCE ASSOCIATION**
VOLUME XVI	**MAY 10/89**	
David Corey **3918 - 4040**		**THE BEHAVIOURAL HEALTH CLINIC,** **TORONTO**
Royston Goldner **4041 - 4060**		**KRG INC.** **DOWNSVIEW**
Victor Politzi William Conner Andrew Rogacki Jeffery Dailey **4061 - 4194**		**PROGRESSIVE CASUALTY INSURANCE COMPANY**
VOLUME XVII	**MAY 11/89**	
James Christie Donald Waugh Lorne McCubbin **4197 - 4356**		**DOMINION OF CANADA GENERAL INSURANCE COMPANY**

Jeffrey Strype David Yeates Terry Taylor Ronald Griffiths **4361 - 4515**		**INSURANCE BROKERS' ASSOCIATION OF ONTARIO**
VOLUME XVIII	**MAY 12/89**	
Steve Crouse **4523 - 4571**		**BETTER AUTO ACCIDENT TREATMENT FOR INJURED VICTIMS OF ONTARIO (LIMITED INTERVENOR)**
VOLUME XIX	**MAY 15/89**	
A. Roger Wingfield Praim Singh Matthew Goetz William Star **4580 - 4725**		**KINGSWAY GENERAL INSURANCE COMPANY**
Ray Rempel **4726 - 4796**		**ONTARIO HEAD INJURY ASSOCIATION**
Barbara Baptiste) William Franks) Jane Staub) Kirby Rowe **4797 - 4880**		**REHABILITATION MANAGEMENT INC.** **CANADIAN PARAPLEGIC ASSOCIATION**
VOLUME XX	**MAY 16/89**	
Terry Boyle Leong Elms Williams **4893 - 5011**		**ROYAL**
Steven Lehmann Clifford Fraser James Perry **5013 - 5162**		**STATE FARM INSURANCE COMPANIES**
VOLUME XXI	**MAY 17/89**	

John Seigel 5170 - 5297		LAVENTHOL & HORWATH
Mark Berenblut 5298 - 5374		BERENBLUT AND ROSEN LTD.
VOLUME XXII	**MAY 18/89**	
Judge Gordon Killeen 5379 - 5460		MIDDLESEX DISTRICT COURT
Nancy Fowler 5461 - 5493		AUTMOBILE ACCIDENT VICTIM, PICKERING, ONTARIO
Fraser 5498 - 5558		STATE FARM
VOLUME XXIII	**MAY 19/89**	
John Evans Marie Zukowski Michael Krashinsky 5561 - 5675		ECONANALYSIS & ASSOCIATES
Sheldon Miller 5688 - 5784		LOPATIN, MILLER, FREEDMAN, BLUESTONE, ERLICH, ROSEN & BARTNICK DETROIT, MICHIGAN
VOLUME XXIV	**MAY 23/89**	
Jack Carr 5793 - 5874 5898 - 6016		UNIVERSITY OF TORONTO, DEPARTMENT OF ECONOMICS
Robert Ramsay 5874 - 5889		MOTORCYCLE AND MOPED INDUSTRY COUNCIL (LIMITED INTERVENOR)
Angus Ross 6018 - 6034		LIMITED INTERVENOR

VOLUME XXV MAY 24/89

Carr 6069 - 6164	UNIVERSITY OF TORONTO
George Priest 6167 - 6282 6333 - 6423	YALE LAW SCHOOL
Catherine Newell Alfred Oakie 6283 - 6332	HAMILTON AUTOMOBILE CLUB

VOLUME XXVI MAY 25/89

Priest 6424 - 6582	YALE LAW SCHOOL
Gerald Baker 6600 - 6717	BAKER, GARBER, DUFFY & PEDERSON P.C. HOBOKEN, NEW JERSEY
John Carson 6718 - 6726	LIMITED INTERVENOR
Fred Hill 6727 - 6744	PARTY

VOLUME XXVII MAY 26/89

Robert Hunter 6755 - 6944	NATIONAL INSURANCE CONSUMERS' ORGANIZATION ALEXANDRIA, VIRGINIA
Justice Coulter Osborne 6945 - 7028	SUPREME COURT OF ONTARIO

VOLUME XXVIII MAY 29/89

Miller 7034 - 7099	WYATT
Trudeau Oakden 7100 - 7173	TILLINGHAST